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ENVOY OF ALEXANDRIA, LLC	900 VIRGINIA AVENUE ALEXANDRIA, VA 22302

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 6/27/2022 through 6/29/2022. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 6/27/22 through 6/29/22. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Three complaints were investigated during the survey (VA00053324-substantiated without deficiency; VA00055516-unsubstantiated; VA00050258-unsubstantiated). The Life Safety Code survey/report will follow. The census in this 111 certified bed facility was 101 at the time of the survey. The survey sample consisted of 33 current Resident reviews and 6 closed record reviews.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, family interview, staff interview, facility document review, and clinical record review, it was determined the facility staff failed to accommodate a resident's need for a	F 558	1. Resident #1was provided a reclining chair and family was informed. The Reclining is stored closed to the second floor solarium when not in use. Family educated on the location of the chair to prevent to misconception that there is no chair. 2. All residents requiring the use of a reclining chair to be out of bed are at risk to be impacted by the alleged deficient practice. A quality review was conducted on residents that require a reclining chair to get out of bed to ensure there is a reclining chair made available for them.	8/3/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

[signature], NHA | Executive Director | 7/22/22

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 558	Continued From page 1 reclining chair for one of 39 residents in the survey sample, Resident #1 (R1). The facility staff failed to provide a reclining chair for R1 to enable the resident to get out of bed. The findings include: R1's diagnoses included, but not limited to, Parkinson's disease and diabetes. On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 3/14/22, R1 was coded as having no cognitive impairment for making daily decisions. R1 was coded as requiring the extensive assistance of staff members for transferring from bed to chair. R1 was observed on the following dates and times: 6/27/22 at 1:47 p.m. and 5:14 p.m.; 6/28/22 at 9:29 a.m. At all observations, R1 was sitting up in bed, with eyes closed. R1 had tube feeding running, and oxygen was administered at 2 liters per minute via tracheostomy. R1 was supported in bed by multiple pillows, and a positioning device at the foot of the bed was in place to prevent further foot drop. R1 was unavailable for interview throughout the survey due to being asleep at every observation. On 6/27/22 at 4:22 p.m., R1's spouse was interviewed. R1's spouse stated the only concern about R1's care at the facility was that the facility staff had not gotten R1 out of bed into a chair since R1 was readmitted from the hospital in June 2022. A review of R1's clinical record revealed the resident was discharged to the hospital on 6/7/22 and readmitted to the facility on 6/14/22.	F 558	Continued From page 1 3. Director of Clinical Services/Unit Managers will educate staff on the location of resident reclining chairs on all the floors. 4. Director of Clinical Services/Unit Manager will conduct quality monitoring audits weekly for 4 weeks then monthly for 2 months to ensure the availability of reclining chair and the functionality of chair on all the resident that required reclining chair to get out of bed. The DCS will report findings to the QAPI Committee monthly and Quality Monitoring Review schedule will be modified based on findings.	8/3/2022

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A review of R1's point of care/ADL (activities of daily living) records for June 2022 revealed no evidence that R1 was transferred from bed to chair between 6/14/22 and 6/27/22.

On 6/28/22 at 2:03 p.m., CNA (certified nursing assistant) #2 was interviewed. She stated she took care of R1 frequently. She stated, "We haven't been getting out of bed because of the chair situation." When asked for more information, she stated R1 needed a reclining chair in order to get out of bed. She stated R1's chair "disappeared" while the resident was in the hospital, and the staff has not been able to find another one for the resident. When asked if the resident usually gets out of bed, she stated R1 usually gets out of bed on Monday, Wednesday, and Friday. She stated she did not know what happened to R1's reclining chair when the resident went to the hospital. When asked if she had reported this to anyone, she stated she had reported it to the unit manager.

On 6/29/22 at 8:24 a.m., OSM #3, the director of rehabilitation, was interviewed. OSM #3 stated he was familiar with R1, as R1 had been a resident at the facility for several years. He stated he thought R1 did not require a specially fitted chair, but only required a generic reclining chair. He stated he had never encountered issues with the facility's reclining chair supply. He stated, "I think we have one on each floor." He stated if a new reclining chair is needed, he goes first to the unit manager, then to the director of nursing or the executive director. He stated the resident did not need a therapy screening or referral in order to be approved for transfer by nursing from bed to a reclining chair.

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F 558	Continued From page 3 On 6/29/22 at 9:18 a.m., LPN (licensed practical nurse) #1, the interim unit manager, was interviewed. She stated she just became aware of R1's need for a reclining chair one the surveyors had arrived at the building. She stated when R1 was discharged to the hospital, another resident had an immediate need for a reclining chair, and the staff gave that resident R1's reclining chair. She stated, "We had to make a choice. We had that one reclining chair." She stated, "They are looking into getting a new chair for [R1]." She stated she is "talking to our ED (executive director) about it." She stated the executive director has to get approval for the purchase. She stated she had spoken earlier with OSM #3, and had asked OSM #3 to help expedite the procurement of the recliner chair. She stated OSM #9, central supply clerk, would know whether a new chair had been ordered yet. On 6/29/22 at 9:23 a.m., OSM #9 was interviewed. He stated a new recliner chair had not yet been ordered. On 6/29/22 at 12:39 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, and ASM #4, the regional director of clinical services, were informed of these concerns. A review of the facility policy, "Social Services - Accommodation of Needs," revealed no information related to the provision of medical equipment to meet the needs of the resident. No further information was provided prior to exit.	F 558		
F 600 SS=G	Free from Abuse and Neglect	F 600		

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F 600	Continued From page 4 CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review and clinical record review it was determined that the facility failed to protect one of 39 residents in the survey sample from resident-to-resident abuse, Resident #44. On 6/24/22, Resident #37 hit Resident #44, which required an emergency room visit where they were diagnosed with a closed fracture of the distal end of the left ulna (1), closed head injury, abrasion of the nose and a closed fracture of the nasal bone, resulting in harm. The findings include: Resident #44's (R44) most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 5/1/2022, the resident scored 15 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident is cognitively intact for	F 600	1. Resident #44 was seen and interviewed by social worker and geriatric psychiatric doctor to ensure resident feels safe and there was not emotional trauma sustained. Resident #44 stated that he feels safe at the facility and denies any emotional trauma. Resident #37 no longer resides at the center. 2. All residents are at risk to be impacted by the alleged deficient practice. A quality review was conducted by the Director of Clinical Services/Social Services focusing on abuse and neglect- interviews were conducted for all resident with a BIMs score of 9 and higher regarding abuse/neglect and feeling safe in the facility. Residents with a BIMs score of less than 9 had skin evaluations completed to determine if there were any signs of abuse/neglect present. 3. Director of Clinical Services/Social Services will educate all staff regarding monitoring and reporting of abuse and neglect in a timely manner. Executive Director and Social Services will re-educate residents on next Resident Council meeting regarding reporting any issues between residents or staff to the Supervisor or Social Worker. 4. Director of Clinical Services/Social Services will conduct quality monitoring audits for abuse and neglect weekly for 4 weeks and then monthly for 2 months. The Director of Clinical Services will report findings to the QAPI Committee monthly for 3 months to maintain substantial compliance.	8/3/2022

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making daily decisions. Section E documented no behaviors. Section G documented R44 requiring supervision with transfers, walking in the room and corridors and locomotion on and off the unit. Section G documented R44 not having any impairment in the functional range of motion to the upper and lower extremities and being not steady but able to stabilize without staff assistance when walking.

On 6/27/2022 at 5:14 p.m., an interview was conducted with R44 in their room. R44 was observed lying in bed and was observed to have a splint wrapped with an elastic bandage on the left forearm. When asked about the splint on the left forearm R44 stated that they were hit by another resident with a cane in the solarium at the end of the hallway the previous Friday. R44 stated that they had a fracture in the arm and a fractured nose from the incident. R44 stated that they had gone to the emergency room and they had taken x-rays, applied the splint and advised them to follow up with an orthopedic physician to see if they needed surgery or not. When asked about the resident who hit them, R44 indicated that Resident #37 (R37) had approached them in the solarium and started hitting them with a cane over "nothing" and they were "crazy." R44 stated that the staff were keeping R37 in their room and were watching them all the time after the incident.

The progress notes for Resident #44 documented in part,
- "6/24/2022 20:19 (8:19 p.m.) Note Text: Resident alert no respiratory distress noted. Resident came to nurses station with blood on his shirt and nose, bruises and bump (swelling) behind left ear. resident c/o (complains of) pain of left arm. Resident stated he was lying on couch

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watching TV in the solarium when resident [Room number identifying R37] approached and accused him of messing up his puzzle in the solarium. Nursing supervisor notified who then notified DON (director of nursing) and called 911. Resident sent to ER (emergency room) for evaluation and treatment."
- "6/25/2022 00:20 (12:20 a.m.) Note Text: Resident back from [Name of hospital] with the diagnosis of closed fracture of distal end of left ulna, abrasion of nose, closed fracture of nasal bone, closed head injury. New order of Amoxicillin-clavulanate (Augmentin) 875-125mg take 1 tablet by mouth 2 times daily for 7 days. Resident denied pain at this time, back in his room at this time will continue to monitor."
- "6/27/2022 16:16 (4:16 p.m.) Note Text: Resident was interview today with DSS (director of social services) about what happened between himself and other resident. Resident told writer what transpired. Resident told writer is feeling much better. Resident told writer he feel safe at [Name of facility] at this time. Resident told writer has no pain. Writer will continue to support resident as needed."

The "After Visit Summary" dated 6/24/2022 for R44 from [Name of hospital] documented in part, "...Reason for Visit: Facial laceration, arm injury. Diagnoses: Closed fracture of distal end of left ulna, unspecified fracture morphology, initial encounter, closed head injury, initial encounter, abrasion of nose, initial encounter, closed fracture of nasal bone, initial encounter...Imaging results: Wrist Left PA (postero anterior) lateral and oblique (final result) Redemonstrated mildly displaced ulnar fracture. No additional fracture or dislocation noted. Marked vascular calcifications are present...Forearm complete Left (final result)

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1. Distal ulnar fracture 2. Dedicated 4 view study of the wrist is recommended to better evaluate the ulnar fracture and evaluate for underlying distal radial fracture...CT (computed tomography) head without contrast (final result) 1. No acute intracranial abnormality. 2. Right nasal bone fracture appears new compared to the prior exam..."

Resident #37's (R37) most recent MDS, a quarterly assessment with an ARD of 4/2/2022, the resident scored 15 out of 15 on the BIMS assessment, indicating the resident is cognitively intact for making daily decisions. Section E documented no behaviors. Section G documented R37 requiring supervision with transfers, walking in the room and corridors and locomotion on and off the unit. Section G further documented R37 being not steady but able to stabilize without staff assistance with walking and having no functional limitation in range of motion in the upper or lower extremities. Section G documented R37 using a walker.

On 6/27/2022 at 1:56 p.m., an interview was conducted with R37 in their room. R37 was observed to have a staff member sitting outside of the room in a chair monitoring the room. R37 stated that the previous Friday they had a fight with another resident who lived across the hall. R37 stated that the police had come and the social worker had advised them they were going to be moved to another room. R37 stated that they did not understand why they were made to stay in their room and not allowed to go outside to smoke with their friends because they were only trying to defend themselves. R37 stated that the other resident hit them in their chest when they asked them a question and they had to fight back

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to protect themselves. R37 stated that they were disappointed because they were not able to walk around the facility currently or visit with their friends. When asked about the other resident, R37 stated that it was the resident in the room across the hall with the cast on the arm. R37 stated that they did not know why they had a cast now. R37 stated that the facility staff were making the fight into a bigger deal than it needed to be because they were just trying to defend themselves.

The progress notes for Resident #37 documented in part:
- "6/28/2022 13:46 (1:46 p.m.) Note Text: Addendum- On 6/24/2022 resident [Room number identifying R44] came to nurses station with blood on his nose, bruises and bump (swelling) behind his left ear. There was also blood on his shirt. Resident [Room number identifying R44] c/o pain on left hand. [Room number identifying R44] stated that he was lying on the couch watching TV in the solarium when above resident [Room number identifying R37] approached and accused him of messing up his puzzle in the solarium. [Room number identifying R44] stated he did not know anything about his puzzle. Then [Room number identifying R37] struck [Room number identifying R44] with his walking cane repeatedly. [Room number identifying R44] stated he used his left arm to cover and protect his face. [Room number identifying R37] then hit his arm too. [Room number identifying R44] ran to nurses station reported writer. Writer called nursing supervisor who then reported to DON and called 911. Resident [Room number identifying R44] was sent to [Name of hospital] ER (emergency room) for evaluation and treatment."

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- "6/27/2022 23:47 (11:47 p.m.) Note Text: Resident transferred from room [Room number] to [Room number] with all medications and personal belongings."
- "6/27/2022 18:25 (6:25 p.m.) Late Entry: Note Text: Resident was interviewed 6/27/22 about what happened between himself and another resident. Resident agreed to move to another room. [Name of Shelter] was contacted to see if they have a placement for resident. Writer left a message. [Name of Shelter] was contacted as well about placement and writer was told no bed is available at this time."
-"6/27/2022 15:00 (3:00 p.m.) ...Behavioral problems are other socially inappropriate behaviors Slammed door on staff when angry and yelling at staff..."
- "6/27/2022 01:43 (1:43 a.m.) Note Text: Resident called for pain medication for generalized pain at 1:25 am. Writer was on [Name of unit] finishing up with another resident. Writer went to [Name of unit] at 1:30am to give [Name of R37] his Percocet. While checking resident's order to pull medication, resident walked from his room to the nurses station and started yelling and cursing writer out. Resident stated that he had been waiting 15 minutes for someone to come and give him his Percocet. Resident snatched medication out of nurses hand, refused water and told nurse, "you drink it." Resident walked back to his room and slammed his door. I followed up with resident immediately and medication was taken. Resident remains in room, lying down. Writer will check on resident soon when he has calmed down to check on his pain. Supervisor notified of outburst."
- "6/25/2022 07:19 (7:19 a.m.) Note Text: At 3:45am resident left his room stating his going outside to get fresh air, resident was told to wait

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until morning which he refused, was also told to sign LOA (leave of absence) which he refused too. Resident stated "I'm not in prison", resident was told how unsafe it was to go out at that time of the night. Supervisor was made aware, resident went outside and came back to the unit at 4:10am. He is in his room at this time, will continue to monitor."
- "6/23/2022 10:28 (10:28 a.m.) Note Text: Resident and I called [Name of Shelter] and left a voicemail. Resident was provide the number to give them a call later. Writer and I called have been trying to call [Name of Shelter] for the few days with no response. Writer left a voicemail."
- "6/16/2022 11:00 (11:00 a.m.) ...Behavioral problems are verbal behaviors (screaming, cursing, etc.) Screaming at Writer using foul Language told writer "you are an animal go back where you came from" with expletives. Slamming his door..."
- "5/4/2022 21:59 (9:59 p.m.) Physician progress note. Note Text: patient has been agitated, hostile to staff. Psych (psychiatry) deemed patient to have mental capacity discussed with DON. Patient is not safe to stay in the facility as he can be a risk to other residents or staff."
- "5/4/2022 09:34 (9:34 a.m.) Note Text: slammed the door in my face. Resident asked if he can put his tray on the treatment cart, I said No, he cannot I asked him politely "Can you give it to me please" He handed the tray to me and slammed the door in my face."
- 5/3/2022 18:13 (6:13 p.m.) Note Text: At approximately 2300 (11:00 p.m.) on 5/2 (5/2/2022), the evening nurse notified this writer that the damaged laptop was no longer working after resident poured water on it. Writer notified the police who returned to the facility at 0700 (7:00 a.m.) on 5/3 (5/3/2022) to document the

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destruction of property. Police stated that writer would have to go to magistrate independently to request the warrant for misdemeanor destruction of property. Police officers spoke with resident in the presence of the writer. Resident recounted the events of the previous night in great detail until the police asked, "what happened with the water and the cart". Resident began stating he "knew nothing" about that started to become agitated. He stood up and left the interview saying, "well if you are going to arrest me then arrest me. I would rather go to jail than be in the ****hole". Resident currently in room alone with 1:1 (one to one) supervision to ensure safety of those around him. Resident's guardian and physician updated on current status."
- "5/2/2022 22:04 (10:04 p.m.) Note Text: This wirter [sic] received call from the nurse on resident's unit at approximately 8:45pm. Nurse reported that resident was upset about pain medication being administered every 6 hours instead of every 2 hours and that he was disrupting the unit. Writer could hear resident yelling in the background loudly and calling the nurse obscene names. Nurse reported that resident was slamming doors, yelling loudly and grabbed the unit phone off of the wall. The nurse stated that resident tried to pull the door shut when she attempted to enter to attend to [R37]'s roommate. Nurse also reported that resident intentionally knocked over the ice pitcher on the medication cart, damaging the medication laptop. Writer notified police and they responded to the building. Writer spoke with police officers on site who stated, "well there is not much we can do in this setting other than speak with him and document". Police officer reported that resident was calm upon their arrival and denied doing anything the [sic] medication cart. Police officer

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stated the laptop remained "on" and working, but that if is [sic] stopped working to call back to document the damage. Increased supervision provided by CNAS (certified nursing assistants) during the remainder of the shift. Writer left message for resident's guardian and physician regarding his behavior. Writer also notified psych (psychiatrist), who stated he would come in the morning to see the resident."

The geriatric psychiatry consult note dated 3/10/2022 for R37 documented in part, "...asked to evaluate cognition. Pt (patient) is alert & engaging. Fully oriented. He admits he is easily frustrated. He feels staff "don't care." He can be very aggressive verbally. Has been known to use racial slurs, hard to direct..."

The geriatric psychiatry consult note dated 5/3/2022 for R37 documented in part, "...Pt has been struggling, he is frustrated he is here. Feels mistreated by staff. Last week was physically aggressive [medical abbreviation for "with"] behaviors that included breaking a laptop..."

The comprehensive care plan for R37 documented in part, "[Name of R37] is at risk for behaviors (verbal/physical aggression, refusal of care, delusions) r/t (related to) diagnosis of adjustment disorder with disturbance of conduct, mood disorder, psychosis and major depression. Date Initiated: 08/16/2021. Revision on: 11/08/2021."

The FRI (facility reported incident) dated 6/25/2022 documented in part, "... [Name of R44] reported resident-resident altercation that took place in the second floor solarium between himself and [Name of R37]. Head-to-toes

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assessment completed, [Name of R44] presented with nose bleed, and a bruise to the back of his neck. [Name of R37] sustained no injury. [Name of R44] transferred to the hospital for further evaluation. Responsible party and Physician notified. Resident send [sic] back to their room under 1:1 observation, one resident send to ED (emergency department) for further evaluation, facility investigation initiated including resident evaluations/interviews, staff interviews and staff education..."

On 6/28/2022 at 11:05 a.m., an interview was conducted with OSM (other staff member) #10, the director of social services. OSM #10 stated that they were not in the facility on 6/24/2022 when R37 and R44 had the altercation. OSM #10 stated that they were called and made aware of the incident that day and had followed up with both residents on 6/27/2022. OSM #10 stated that R37 had previous behaviors of slamming doors, destruction of facility property and being verbally abusive to staff members but had not displayed any aggression towards another resident that they were aware of prior to that day. OSM #10 stated that they had been attempting to find alternate housing for R37 since they had been to court and deemed competent but had not been able to find a safe discharge location for them. OSM #10 stated that R37 was alert and oriented and had stated that R44 had hit them in the chest first when they had interviewed them on 6/27/2022 regarding the incident. OSM #10 stated that the incident between R44 and R37 was not witnessed by any staff or other residents. OSM #10 stated that since 6/24/2022, R37 had been on 1 to 1 monitoring and staff were with them if they left the room for anything. OSM #10 stated that R44 had never displayed any

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behaviors and was always a quiet person who enjoyed sitting in the Solarium watching television.

On 6/28/2022 at 12:54 p.m., an interview was conducted with LPN (licensed practical nurse) #7. LPN #7 stated that R37 had anger issues and would throw things at staff when they became angry. LPN #7 stated that there were times when R37 was very pleasant and charming to the staff. LPN #7 stated that they were not aware of any aggression from R37 towards another resident prior to the altercation with R44 on 6/24/2022. LPN #7 stated that they had kept R37 in their room with 1 to 1 monitoring and a chaperone if they left the room since the altercation on 6/24/2022. LPN #7 stated that R44 had never displayed any aggressive behaviors and was always very social and friendly. LPN #7 stated that any resident to resident altercation was intervened upon and the residents were separated and it was immediately reported to the director of nursing or administrator. LPN #7 stated that both R37 and R44 were alert and oriented to person, place, time and situation.

On 6/28/2022 at 1:48 p.m., an interview was conducted with LPN #4, unit manager. LPN #4 stated that residents were separated if involved in a resident to resident altercation. LPN #4 stated that the residents would be assessed, EMS (emergency medical services) and police would be notified and they would report the incident to the supervisor and the director of nursing. LPN #4 stated that they would assess the residents depending on the behavior of the residents involved and keep everyone safe.

On 6/28/2022 at 2:00 p.m., an interview was

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conducted with LPN #1, unit manager. LPN #1 stated that R37 would lash out at staff at times and it was "like walking on eggshells." LPN #1 stated that R37 had destroyed a facility laptop and did not care. LPN #1 stated that they had to keep other residents out of the way when R37 lashed out at the staff. LPN #1 stated that they were not aware of any incidents with other residents prior to 6/24/2022 with R37. LPN #1 stated that R37 mostly had verbal behaviors that were off and on. LPN #1 stated that they had not had any conversations with R37 since the incident on 6/24/2022. LPN #1 stated that R44 had no history of any behaviors and was always pleasant.

On 6/28/2022 at 2:11 p.m., an interview was conducted with ASM (administrative staff member) #2, the director of nursing. ASM #2 stated that R37 was competent and had been to court to have the guardianship lifted. ASM #2 stated that R37 had previously damaged a facility laptop when the nurse would not give them additional pain medications. ASM #2 stated that R37 had been placed on 1 to 1 monitoring after the incident on 5/2/2022 when they damaged the facility laptop and displayed behaviors towards staff. ASM #2 stated that the police had come at that time and R37 had lied to the police saying they did not remember anything. ASM #2 stated that R37 did not lack capacity and the police knew they were lying but could not do anything. ASM #2 stated that the previous DON (director of nursing) had moved R37 to a private room and placed them on 1 to 1 monitoring at that time and there had been no further behaviors. ASM #2 stated that they had ended the 1 to 1 monitoring around 5/24/2022 because R37 was not displaying any behaviors and the physician had

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determined that it could be lifted. ASM #2 stated that they were having the physician fax over a note documenting this. ASM #2 stated that they felt that R37 waited until late on 6/24/2022 after administrative staff had left for the day before approaching R44 in the solarium. ASM #2 stated that on 6/24/2022 after 8:00 p.m., they received a phone call from the facility saying that R44 had been hit with a cane and was going to the hospital. ASM #2 stated that when they arrived R44 had already left for the hospital and R37 was in their room. ASM #2 stated that they spoke with R37 that night they said they did it because R44 touched their puzzle. ASM #2 stated that R37 had "cussed me out" when they were told they were going to have the 1 to 1 monitoring and going to move to another room. ASM #2 stated that they left the facility prior to R44 coming back from the hospital. ASM #2 stated that they saw R44 on 6/27/2022 with the bruise on the neck, broken nose and arm. ASM #2 stated that they asked R44 why they did not call for help on 6/24/2022 and what happened. ASM #2 stated that R44 explained that R37 thought they messed up their puzzle. ASM #2 stated that R44 would not press charges against R37 because they did not want them to get into trouble. ASM #2 stated that R37's actions were criminal.

On 6/28/2022 at 4:36 p.m., an interview was conducted with CNA (certified nursing assistant) #9. CNA #9 stated that they were working on 6/24/2022 when the altercation between R37 and R44 occurred. CNA #9 stated that near the end of the evening shift they were at the nurses station when R44 came up to the nurses station with blood on their nose and said that R37 had hit them with a cane. CNA #9 stated that R44 had told them that R37 had accused them of messing

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up their puzzle. CNA #9 stated that the nurse had called 911 to send R44 to the emergency room and they had made sure R37 was in their room and monitored 1 on 1. CNA #9 stated that there were no staff or residents who witnessed the incident. CNA #9 stated that R44 normally sat down in the solarium every day watching television. CNA #9 stated that R37 was verbally abusive to staff at times and had slammed doors at times. CNA #9 stated that if a resident to resident altercation was witnessed they immediately separated the residents and called for help. CNA #9 stated that they reported any incidents to the nurse. CNA #9 stated that they reported this because residents could abuse other residents.

On 6/29/2022 at 10:08 a.m., an interview was conducted with ASM #5, medical doctor. ASM #5 stated that they care for R37. ASM #5 stated that when R37 gets emotional they could become dangerous and verbally difficult and act out. ASM #5 stated that normally R37 was not dangerous. ASM #5 stated that R37 had destroyed some property but they did not feel that they could give someone a concussion. ASM #5 stated that they had not seen R37 since the incident on 6/24/2022 with R44 but based on what was going on with them they felt that everything was behavioral. ASM #5 stated that they felt that if R37 did not get what they wanted things would keep happening and R37 needed to be safely discharged. ASM #5 stated that they had recommended for the 1 on 1 monitoring to continue and for nursing to keep working on a safe discharge. ASM #5 stated that they felt that R37 did not like R44 for some reason and was mad at them.

The facility policy "Abuse, Neglect, Exploitation &

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F 600	Continued From page 18 Misappropriation" with a revision date of 11/28/2017 documented in part, "It is inherent in the nature and dignity of each resident at the center that he/she be afforded basic human rights, including the right to be free from abuse, neglect, mistreatment, exploitation and/or misappropriation of property...Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish...Furthermore, the Administration of The Company recognizes that resident abuse can be committed by other residents, visitors, or volunteers..." On 6/28/2022 at 3:48 p.m., ASM (administrative staff member) #1, the executive director and ASM #2, the director of nursing were made aware of the concern for harm. No further information was provided prior to exit. Reference: 1. ulna Of the 206 bones in your body, three of them are in your arm: the humerus, radius, and ulna. this information was obtained from the website: https://medlineplus.gov/arminjuriesanddisorders.html	F 600		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,	F 607	1. Resident #44 was seen and interviewed by social worker and geriatric psychiatric doctor to ensure resident feels safe and that no emotional trauma was sustained. Resident #44 indicated that he feels safe at the facility and denies any emotional trauma. Resident #37 is no longer a resident at the center.	8/3/2022

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§483.12(b)(2) Establish policies and procedures to investigate any such allegations, and

§483.12(b)(3) Include training as required at paragraph §483.95,
This REQUIREMENT is not met as evidenced by:
Based on resident interview, staff interview, facility document review and clinical record review it was determined that the facility staff failed to implement their abuse policy and procedures to ensure one of 39 residents in the survey sample was free from abuse, Resident #44. On 6/24/22, Resident #37 hit Resident #44, which required an emergency room visit where they were diagnosed with a closed fracture of the distal end of the left ulna (1), closed head injury, abrasion of the nose and a closed fracture of the nasal bone.

The findings include:

Resident #44's (R44) most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 5/1/2022, the resident scored 15 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident is cognitively intact for making daily decisions. Section E documented no behaviors. Section G documented R44 requiring supervision with transfers, walking in the room and corridors and locomotion on and off the unit. Section G documented R44 not having any impairment in the functional range of motion to the upper and lower extremities and being not steady but able to stabilize without staff assistance when walking.

On 6/27/2022 at 5:14 p.m., an interview was

2. All residents have the potential to be impacted by the alleged deficient practice. Quality review conducted by the Director of Clinical Services/Unit Managers/Social Services regarding abuse and neglect on all residents. Residents with a BIMS score of 9 and higher were interviewed and they were also questioned if they feel safe at the center. Residents with a BIMS score of less than 9 had skin evaluations completed to determine if there were any signs of abuse/neglect present. Quality review conducted by the Director of Clinical Services/Unit Managers/Social Services of post event management to include supervision of residents with behaviors.
3. All staff with be educated by the Social Service Director and Director of Clinical Services/Unit Managers on: abuse and neglect, dementia behavior training and managing post event supervision.
The interdisciplinary team will review each abuse/neglect situation to determine that the appropriate post event interventions are put into place as indicated including supervision of participants.
In the morning clinical meetings a review of residents with behaviors impacting others will be reviewed to ensure that proper interventions are put into place to prevent abuse/neglect situations.

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F 607	Continued From page 20 conducted with R44 in their room. R44 was observed lying in bed and was observed to have a splint wrapped with an elastic bandage on the left forearm. When asked about the splint on the left forearm R44 stated that they were hit by another resident with a cane in the solarium at the end of the hallway the previous Friday. R44 stated that they had a fracture in the arm and a fractured nose from the incident. R44 stated that they had gone to the emergency room and they had taken x-rays, applied the splint and advised them to follow up with an orthopedic physician to see if they needed surgery or not. When asked about the resident who hit them, R44 indicated that Resident #37 (R37) had approached them in the solarium and started hitting them with a cane over "nothing" and they were "crazy." R44 stated that the staff were keeping R37 in their room and were watching them all the time after the incident. The progress notes for Resident #44 documented in part; - "6/24/2022 20:19 (8:19 p.m.) Note Text: Resident alert no respiratory distress noted. Resident came to nurses station with blood on his shirt and nose, bruises and bump (swelling) behind left ear. resident c/o (complains of) pain of left arm. Resident stated he was lying on couch watching TV in the solarium when resident [Room number identifying R37] approached and accused him of messing up his puzzle in the solarium. Nursing supervisor notified who then notified DON (director of nursing) and called 911. Resident sent to ER (emergency room) for evaluation and treatment." - "6/25/2022 00:20 (12:20 a.m.) Note Text: Resident back from [Name of hospital] with the diagnosis of closed fracture of distal end of left ulna, abrasion of nose, closed fracture of nasal	F 607	Continued From page 20 4. The Executive Director/Director of Clinical Services/Unit Managers to conduct quality monitoring for abuse/neglect and post event supervision weekly x 6 weeks. The Executive Director/Director of Clinical Services/Managers to conduct quality monitoring of residents with behaviors affecting others to ensure proper management weekly x 6 weeks. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services / designee.	8/3/2022

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bone, closed head injury. New order of Amoxicillin-clavulanate (Augmentin) 875-125mg take 1 tablet by mouth 2 times daily for 7 days. Resident denied pain at this time, back in his room at this time will continue to monitor."

The "After Visit Summary" dated 6/24/2022 for R44 from [Name of hospital] documented in part, "...Reason for Visit: Facial laceration, arm injury. Diagnoses: Closed fracture of distal end of left ulna, unspecified fracture morphology, initial encounter, closed head injury, initial encounter, abrasion of nose, initial encounter, closed fracture of nasal bone, initial encounter...Imaging results: Wrist Left PA (postero anterior) lateral and oblique (final result) Redemonstrated mildly displaced ulnar fracture. No additional fracture or dislocation noted. Marked vascular calcifications are present...Forearm complete Left (final result) 1. Distal ulnar fracture 2. Dedicated 4 view study of the wrist is recommended to better evaluate the ulnar fracture and evaluate for underlying distal radial fracture...CT (computed tomography) head without contrast (final result) 1. No acute intracranial abnormality. 2. Right nasal bone fracture appears new compared to the prior exam..."

Resident #37's (R37) most recent MDS, a quarterly assessment with an ARD of 4/2/2022, the resident scored 15 out of 15 on the BIMS assessment, indicating the resident is cognitively intact for making daily decisions. Section E documented no behaviors. Section G documented R37 requiring supervision with transfers, walking in the room and corridors and locomotion on and off the unit. Section G further documented R37 being not steady but able to stabilize without staff assistance with walking and

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having no functional limitation in range of motion in the upper or lower extremities. Section G documented R37 using a walker.

On 6/27/2022 at 1:56 p.m., an interview was conducted with R37 in their room. R37 was observed to have a staff member sitting outside of the room in a chair monitoring the room. R37 stated that the previous Friday they had a fight with another resident who lived across the hall. R37 stated that the police had come and the social worker had advised them they were going to be moved to another room. R37 stated that they did not understand why they were made to stay in their room and not allowed to go outside to smoke with their friends because they were only trying to defend themselves. R37 stated that the other resident hit them in their chest when they asked them a question and they had to fight back to protect themselves. R37 stated that they were disappointed because they were not able to walk around the facility currently or visit with their friends. When asked about the other resident, R37 stated that it was the resident in the room across the hall with the cast on the arm. R37 stated that they did not know why they had a cast now. R37 stated that the facility staff were making the fight into a bigger deal than it needed to be because they were just trying to defend themselves.

The progress notes for Resident #37 documented in part;

- "6/16/2022 11:00 (11:00 a.m.) ...Behavioral problems are verbal behaviors (screaming, cursing, etc.) Screaming at Writer using foul Language told writer "you are an animal go back where you came from" with expletives. Slamming

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his door..."
- "5/4/2022 21:59 (9:59 p.m.) Physician progress note. Note Text: patient has been agitated, hostile to staff. Psych (psychiatry) deemed patient to have mental capacity discussed with DON. Patient is not safe to stay in the facility as he can be a risk to other residents or staff."
- "5/4/2022 09:34 (9:34 a.m.) Note Text: slammed the door in my face. Resident asked if he can put his tray on the treatment cart, I said No, he cannot I asked him politely "Can you give it to me please" He handed the tray to me and slammed the door in my face."
- 5/3/2022 18:13 (6:13 p.m.) Note Text: At approximately 2300 (11:00 p.m.) on 5/2 (5/2/2022), the evening nurse notified this writer that the damaged laptop was no longer working after resident poured water on it. Writer notified the police who returned to the facility at 0700 (7:00 a.m.) on 5/3 (5/3/2022) to document the destruction of property. Police stated that writer would have to go to magistrate independently to request the warrant for misdemeanor destruction of property. Police officers spoke with resident in the presence of the writer. Resident recounted the events of the previous night in great detail until the police asked, "what happened with the water and the cart". Resident began stating he "knew nothing" about that started to become agitated. He stood up and left the interview saying, "well if you are going to arrest me then arrest me. I would rather go to jail than be in the ****hole". Resident currently in room alone with 1:1 (one to one) supervision to ensure safety of those around him. Resident's guardian and physician updated on current status."
- "5/2/2022 22:04 (10:04 p.m.) Note Text: This wirter [sic] received call from the nurse on resident's unit at approximately 8:45pm. Nurse

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reported that resident was upset about pain medication being administered every 6 hours instead of every 2 hours and that he was disrupting the unit. Writer could hear resident yelling in the background loudly and calling the nurse obscene names. Nurse reported that resident was slamming doors, yelling loudly and grabbed the unit phone off of the wall. The nurse stated that resident tried to pull the door shut when she attempted to enter to attend to [R37]'s roommate. Nurse also reported that resident intentionally knocked over the ice pitcher on the medication cart, damaging the medication laptop. Writer notified police and they responded to the building. Writer spoke with police officers on site who stated, "well there is not much we can do in this setting other than speak with him and document". Police officer reported that resident was calm upon their arrival and denied doing anything the [sic] medication cart. Police officer stated the laptop remained "on" and working, but that if is [sic] stopped working to call back to document the damage. Increased supervision provided by CNAS (certified nursing assistants) during the remainder of the shift. Writer left message for resident's guardian and physician regarding his behavior. Writer also notified psych (psychiatrist), who stated he would come in the morning to see the resident."

The geriatric psychiatry consult note dated 3/10/2022 for R37 documented in part, "...asked to evaluate cognition. Pt (patient) is alert & engaging. Fully oriented. He admits he is easily frustrated. He feels staff "don't care." He can be very aggressive verbally. Has been known to use racial slurs, hard to direct..."

The geriatric psychiatry consult note dated

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5/3/2022 for R37 documented in part, "...Pt has been struggling, he is frustrated he is here. Feels mistreated by staff. Last week was physically aggressive [medical abbreviation for "with"] behaviors that included breaking a laptop..."

The comprehensive care plan for R37 documented in part, "[Name of R37] is at risk for behaviors (verbal/physical aggression, refusal of care, delusions) r/t (related to) diagnosis of adjustment disorder with disturbance of conduct, mood disorder, psychosis and major depression. Date Initiated: 08/16/2021. Revision on: 11/08/2021."

The FRI (facility reported incident) dated 6/25/2022 documented in part, "...[Name of R44] reported resident-resident altercation that took place in the second floor solarium between himself and [Name of R37]. Head-to-toes assessment completed, [Name of R44] presented with nose bleed, and a bruise to the back of his neck. [Name of R37] sustained no injury. [Name of R44] transferred to the hospital for further evaluation. Responsible party and Physician notified. Resident send [sic] back to their room under 1:1 observation, one resident send to ED (emergency department) for further evaluation, facility investigation initiated including resident evaluations/interviews, staff interviews and staff education..."

On 6/28/2022 at 11:05 a.m., an interview was conducted with OSM (other staff member) #10, the director of social services. OSM #10 stated that they were not in the facility on 6/24/2022 when R37 and R44 had the altercation. OSM #10 stated that they were called and made aware of the incident that day and had followed up with

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both residents on 6/27/2022. OSM #10 stated that R37 had previous behaviors of slamming doors, destruction of facility property and being verbally abusive to staff members but had not displayed any aggression towards another resident that they were aware of prior to that day. OSM #10 stated that they had been attempting to find alternate housing for R37 since they had been to court and deemed competent but had not been able to find a safe discharge location for them. OSM #10 stated that R37 was alert and oriented and had stated that R44 had hit them in the chest first when they had interviewed them on 6/27/2022 regarding the incident. OSM #10 stated that the incident between R44 and R37 was not witnessed by any staff or other residents. OSM #10 stated that since 6/24/2022, R37 had been on 1 to 1 monitoring and staff were with them if they left the room for anything. OSM #10 stated that R44 had never displayed any behaviors and was always a quiet person who enjoyed sitting in the Solarium watching television.

On 6/28/2022 at 12:54 p.m., an interview was conducted with LPN (licensed practical nurse) #7. LPN #7 stated that R37 had anger issues and would throw things at staff when they became angry. LPN #7 stated that there were times when R37 was very pleasant and charming to the staff. LPN #7 stated that they were not aware of any aggression from R37 towards another resident prior to the altercation with R44 on 6/24/2022. LPN #7 stated that they had kept R37 in their room with 1 to 1 monitoring and a chaperone if they left the room since the altercation on 6/24/2022. LPN #7 stated that R44 had never displayed any aggressive behaviors and was always very social and friendly. LPN #7 stated

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that any resident to resident altercation was intervened upon and the residents were separated and it was immediately reported to the director of nursing or administrator. LPN #7 stated that both R37 and R44 were alert and oriented to person, place, time and situation.

On 6/28/2022 at 2:00 p.m., an interview was conducted with LPN #1, unit manager. LPN #1 stated that R37 would lash out at staff at times and it was "like walking on eggshells." LPN #1 stated that R37 had destroyed a facility laptop and did not care. LPN #1 stated that they had to keep other residents out of the way when R37 lashed out at the staff. LPN #1 stated that they were not aware of any incidents with other residents prior to 6/24/2022 with R37. LPN #1 stated that R37 mostly had verbal behaviors that were off and on. LPN #1 stated that they had not had any conversations with R37 since the incident on 6/24/2022. LPN #1 stated that R44 had no history of any behaviors and was always pleasant.

On 6/28/2022 at 2:11 p.m., an interview was conducted with ASM (administrative staff member) #2, the director of nursing. ASM #2 stated that R37 was competent and had been to court to have the guardianship lifted. ASM #2 stated that R37 had previously damaged a facility laptop when the nurse would not give them additional pain medications. ASM #2 stated that the police had come at that time and R37 had lied to the police saying they did not remember anything. ASM #2 stated that R37 did not lack capacity and the police knew they were lying but could not do anything. ASM #2 stated that the previous DON (director of nursing) had moved R37 to a private room and placed them on 1 to 1

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monitoring at that time and there had been no further behaviors. ASM #2 stated that they had ended the 1 to 1 monitoring around 5/24/2022 because R37 was not displaying any behaviors and the physician had determined that it could be lifted. ASM #2 stated that they were having the physician fax over a note documenting this. ASM #2 stated that they felt that R37 waited until late on 6/24/2022 after administrative staff had left for the day before approaching R44 in the solarium. ASM #2 stated that on 6/24/2022 after 8:00 p.m., they received a phone call from the facility saying that R44 had been hit with a cane and was going to the hospital. ASM #2 stated that when they arrived R44 had already left for the hospital and R37 was in their room. ASM #2 stated that they spoke with R37 that night they said they did it because R44 touched their puzzle. ASM #2 stated that R37 had "cussed me out" when they were told they were going to have the 1 to 1 monitoring and going to move to another room. ASM #2 stated that they left the facility prior to R44 coming back from the hospital. ASM #2 stated that they saw R44 on 6/27/2022 with the bruise on the neck, broken nose and arm. ASM #2 stated that they asked R44 why they did not call for help on 6/24/2022 and what happened. ASM #2 stated that R44 explained that R37 thought they messed up their puzzle. ASM #2 stated that R44 would not press charges against R37 because they did not want them to get into trouble. ASM #2 stated that R37's actions were criminal.

On 6/28/2022 at 4:36 p.m., an interview was conducted with CNA (certified nursing assistant) #9. CNA #9 stated that they were working on 6/24/2022 when the altercation between R37 and R44 occurred. CNA #9 stated that near the end

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of the evening shift they were at the nurses station when R44 came up to the nurses station with blood on their nose and said that R37 had hit them with a cane. CNA #9 stated that R44 had told them that R37 had accused them of messing up their puzzle. CNA #9 stated that the nurse had called 911 to send R44 to the emergency room and they had made sure R37 was in their room and monitored 1 on 1. CNA #9 stated that there were no staff or residents who witnessed the incident. CNA #9 stated that R44 normally sat down in the solarium every day watching television. CNA #9 stated that R37 was verbally abusive to staff at times and had slammed doors at times. CNA #9 stated that if a resident to resident altercation was witnessed they immediately separated the residents and called for help. CNA #9 stated that they reported any incidents to the nurse. CNA #9 stated that they reported this because residents could abuse other residents.

On 6/29/2022 at 10:08 a.m., an interview was conducted with ASM #5, medical doctor. ASM #5 stated that they care for R37. ASM #5 stated that when R37 gets emotional they could become dangerous and verbally difficult and act out. ASM #5 stated that normally R37 was not dangerous. ASM #5 stated that R37 had destroyed some property but they did not feel that they could give someone a concussion. ASM #5 stated that they had not seen R37 since the incident on 6/24/2022 with R44 but based on what was going on with them they felt that everything was behavioral. ASM #5 stated that they felt that if R37 did not get what they wanted things would keep happening and R37 needed to be safely discharged. ASM #5 stated that they had recommended for the 1 on 1 monitoring to continue and for nursing to

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keep working on a safe discharge. ASM #5 stated that they felt that R37 did not like R44 for some reason and was mad at them.

The facility policy "Abuse, Neglect, Exploitation & Misappropriation" with a revision date of 11/28/2017 documented in part, "It is inherent in the nature and dignity of each resident at the center that he/she be afforded basic human rights, including the right to be free from abuse, neglect, mistreatment, exploitation and/or misappropriation of property...Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish...Furthermore, the Administration of The Company recognizes that resident abuse can be committed by other residents, visitors, or volunteers..." The policy further documented, "...The center is committed to the prevention of abuse, neglect, misappropriation of resident property, and exploitation. The following systems have been implemented: ...Monitoring of residents who may be at risk is the responsibility of all facility staff. This includes monitoring residents who are at risk or vulnerable for abuse, for indications of changes in behavior, changes in condition or other non-verbal indication of abuse..."

On 6/28/2022 at 5:30 p.m., ASM (administrative staff member) #1, the executive director and ASM #2, the director of nursing were made aware of the concern.

No further information was provided prior to exit.

Reference:

1. ulna

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F 607	Continued From page 31 Of the 206 bones in your body, three of them are in your arm: the humerus, radius, and ulna. this information was obtained from the website: https://medlineplus.gov/arminjuriesanddisorders.html	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F 609	1. Abuse and Neglect reporting timeframes were reviewed with the Director of Nursing to ensure all incident are reported on a timely manner. 2. All residents are at risk to be impacted by the alleged deficient practice. A quality review was conducted by the Regional Director/designee to identify any other regulatory guideline that needs to be address in order to maintain substantial compliance. 3. Regional Director of Nursing will educate the Director of Nursing on regulatory guideline for reporting abuse and neglect to the appropriate state agencies on a timely manner. 4. Regional Director of Nursing/designee will monitor the timely reporting of incidents to the appropriate state agencies weekly for 4 weeks them monthly for 3 months. Findings to be reported to the QAPI committee for further recommendations.	08/03/22

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Based on resident interview, staff interview, facility document review and clinical record review it was determined that the facility staff failed to report to the State Survey Agency timely, an allegation of abuse, for one of 39 residents in the survey sample, Resident #44; which required an emergency room visit where they were diagnosed with a closed fracture of the distal end of the left ulna (1), closed head injury, abrasion of the nose and a closed fracture of the nasal bone.

The findings include:

Resident #44's (R44) most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 5/1/2022, the resident scored 15 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident is cognitively intact for making daily decisions. Section E documented no behaviors.

On 6/27/2022 at 5:14 p.m., an interview was conducted with R44 in their room. R44 was observed lying in bed and was observed to have a splint wrapped with an elastic bandage on the left forearm. When asked about the splint on the left forearm R44 stated that they were hit by another resident with a cane in the solarium at the end of the hallway the previous Friday. R44 stated that they had a fracture in the arm and a fractured nose from the incident. R44 stated that they had gone to the emergency room and they had taken x-rays, applied the splint and advised them to follow up with an orthopedic physician to see if they needed surgery or not. When asked about the resident who hit them, R44 indicated that Resident #37 (R37) had approached them in the solarium and started hitting them with a cane

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over "nothing" and they were "crazy." R44 stated that the staff were keeping R37 in their room and were watching them all the time after the incident.

The progress notes for Resident #44 documented in part,
- "6/24/2022 20:19 (8:19 p.m.) Note Text: Resident alert no respiratory distress noted. Resident came to nurses station with blood on his shirt and nose, bruises and bump (swelling) behind left ear. resident c/o (complains of) pain of left arm. Resident stated he was lying on couch watching TV in the solarium when resident [Room number identifying R37] approached and accused him of messing up his puzzle in the solarium. Nursing supervisor notified who then notified DON (director of nursing) and called 911. Resident sent to ER (emergency room) for evaluation and treatment."
- "6/25/2022 00:20 (12:20 a.m.) Note Text: Resident back from [Name of hospital] with the diagnosis of closed fracture of distal end of left ulna, abrasion of nose, closed fracture of nasal bone, closed head injury. New order of Amoxicillin-clavulanate (Augmentin) 875-125mg take 1 tablet by mouth 2 times daily for 7 days. Resident denied pain at this time, back in his room at this time will continue to monitor."

The "After Visit Summary" dated 6/24/2022 for R44 from [Name of hospital] documented in part, "...Reason for Visit: Facial laceration, arm injury. Diagnoses: Closed fracture of distal end of left ulna, unspecified fracture morphology, initial encounter, closed head injury, initial encounter, abrasion of nose, initial encounter, closed fracture of nasal bone, initial encounter...Imaging results: Wrist Left PA (postero anterior) lateral and oblique (final result) Redemonstrated mildly

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displaced ulnar fracture. No additional fracture or dislocation noted. Marked vascular calcifications are present...Forearm complete Left (final result) 1. Distal ulnar fracture 2. Dedicated 4 view study of the wrist is recommended to better evaluate the ulnar fracture and evaluate for underlying distal radial fracture...CT (computed tomography) head without contrast (final result) 1. No acute intracranial abnormality. 2. Right nasal bone fracture appears new compared to the prior exam..."

Resident #37's (R37) most recent MDS, a quarterly assessment with an ARD of 4/2/2022, the resident scored 15 out of 15 on the BIMS assessment, indicating the resident is cognitively intact for making daily decisions. Section E documented no behaviors.

On 6/27/2022 at 1:56 p.m., an interview was conducted with R37 in their room. R37 was observed to have a staff member sitting outside of the room in a chair monitoring the room. R37 stated that the previous Friday they had a fight with another resident who lived across the hall. R37 stated that the police had come and the social worker had advised them they were going to be moved to another room. R37 stated that they did not understand why they were made to stay in their room and not allowed to go outside to smoke with their friends because they were only trying to defend themselves. R37 stated that the other resident hit them in their chest when they asked them a question and they had to fight back to protect themselves. R37 stated that they were disappointed because they were not able to walk around the facility currently or visit with their friends. When asked about the other resident, R37 stated that it was the resident in the room

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across the hall with the cast on the arm. R37 stated that they did not know why they had a cast now. R37 stated that the facility staff were making the fight into a bigger deal than it needed to be because they were just trying to defend themselves.

The progress notes for Resident #37 documented in part:
- "6/28/2022 13:46 (1:46 p.m.) Note Text: Addendum- On 6/24/2022 resident [Room number identifying R44] came to nurses station with blood on his nose, bruises and bump (swelling) behind his left ear. There was also blood on his shirt. Resident [Room number identifying R44] c/o pain on left hand. [Room number identifying R44] stated that he was lying on the couch watching TV in the solarium when above resident [Room number identifying R37] approached and accused him of messing up his puzzle in the solarium. [Room number identifying R44] stated he did not know anything about his puzzle. Then [Room number identifying R37] struck [Room number identifying R44] with his walking cane repeatedly. [Room number identifying R44] stated he used his left arm to cover and protect his face. [Room number identifying R37] then hit his arm too. [Room number identifying R44] ran to nurses station reported writer. Writer called nursing supervisor who then reported to DON and called 911. Resident [Room number identifying R44] was sent to [Name of hospital] ER (emergency room) for evaluation and treatment."

The FRI (facility reported incident) dated 6/25/2022 documented in part, "Facility Name: [Name of Facility], Report Date: 06/25/2022, Incident Date: 06/24/2022..." The FRI further

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documented, "...[Name of R44] reported resident-resident altercation that took place in the second floor solarium between himself and [Name of R37]. Head-to-toes assessment completed, [Name of R44] presented with nose bleed, and a bruise to the back of his neck. [Name of R37] sustained no injury. [Name of R44] transferred to the hospital for further evaluation. Responsible party and Physician notified. Resident send [sic] back to their room under 1:1 observation, one resident send to ED (emergency department) for further evaluation, facility investigation initiated including resident evaluations/interviews, staff interviews and staff education..." The attached fax confirmation documented notification to the state agency on 6/25/2022 at 16:37 (4:37 p.m.).

On 6/28/2022 at 2:11 p.m., an interview was conducted with ASM (administrative staff member) #2, the director of nursing. ASM #2 stated that on 6/24/2022 after 8:00 p.m., they received a phone call from the facility saying that R44 had been hit with a cane and was going to the hospital. ASM #2 stated that when they arrived at the facility, R44 had already left for the hospital and R37 was in their room. ASM #2 stated that they left the facility prior to R44 coming back from the hospital. ASM #2 stated that they had come back to the facility on 6/25/2022 to send the FRI to the state agency. ASM #2 stated that they had come to the facility on 6/24/2022 because they thought that they had a two hour window to report the incident and they had debated on the window. ASM #2 stated that they had reviewed their policy and talked with a corporate contact who advised them that they had twenty-four hours to send the report. ASM #2 stated that when they came in on 6/24/2022

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they knew that R37 had hit R44 and caused bodily injury requiring them to have to go to the emergency room so they may have "dropped the ball" on sending the report in the two hour timeframe.

The facility policy "Reporting Reasonable Suspicion of a Crime" with a revision date of 11/28/2017 documented in part, "...If the event that causes the reasonable suspicion results in serious bodily injury, the report must be made immediately after forming the suspicion (but not later than 2 hours after forming the suspicion). Otherwise, the report must be made not later than 24 hours after forming the suspicion. 3. Where an alleged violation of abuse, neglect, misappropriation of resident property, or exploitation also gives rise to a reasonable suspicion of a crime, reports will be made to the Administrator, to the State Survey Agency, and to local law enforcement...Time period for Individual Reporting, Serious Bodily Injury- 2 hour limit: If the event that caused the reasonable suspicion results in serious bodily injury to a resident, the covered individual shall report the suspicion immediately, but not later than 2 hours after forming the suspicion..."

On 6/28/2022 at 5:30 p.m., ASM (administrative staff member) #1, the executive director and ASM #2, the director of nursing were made aware of the concern.

No further information was provided prior to exit.

Reference:

1. ulna
Of the 206 bones in your body, three of them are

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F 609	Continued From page 38 in your arm: the humerus, radius, and ulna. this information was obtained from the website: https://medlineplus.gov/arminjuriesanddisorders.html	F 609		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to complete a significant change MDS for one of 39 residents in the survey sample, Resident #82. Resident #82 was admitted to hospice on 12/22/21. There was no significant change MDS completed for the provision of hospice services. The findings include: On the most recent MDS (Minimum Data Set) a quarterly assessment with an ARD (Assessment Reference Date) of 6/8/22, Resident #82 scored a 15 out of a possible 15 on the BIMS (Brief	F 637	1. Resident #82 was observed to have missed a significant change MDS in December of 2021. RN #1 was educated about ensuring Significant Change MDS is completed per the RAI. 2. All residents who require hospice services are at risk to be impacted by the alleged deficient practice. A quality review was completed to determine if any residents had a change of condition that required a significant change Minimum Data Set addressing hospice. 3. Director of Clinical Services to educate Minimum Data Set Coordinators regarding significant change Minimum Data Set requirements per the RAI in regards to hospice services. Director of Nursing, or designee, to educate Unit Managers regarding reporting all changes in hospice services to the Minimum Data Set Coordinator during Clinical Morning Meeting to identify significant changes. 4. Director of Clinical Services/Unit Managers to conduct Quality Monitoring Review weekly for 4 weeks then monthly for 2 months to ensure residents with a change in hospice services have a Significant Change Minimum Data Set submitted timely and per the RAI. The Director of Clinical Services will reporting findings to the QAPI Committee and Quality Monitoring schedule will be modified based on findings.	8/3/2022

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Interview for Mental Status) indicating the resident was cognitively intact in ability to make daily life decisions. The resident was coded as requiring supervision for eating and extensive to total care for all other areas of activities of daily living.

A review of the clinical record revealed a physician's order dated 12/22/21 and rewritten again on 4/1/22 for hospice services.

Further review of the clinical record revealed a nurse's note dated 12/22/21 that documented, "Resident admitted into [name of] Hospice, with Diagnosis: CHF (congestive heart failure) and COPD (chronic obstructive pulmonary disease)..."

A review of the above MDS for Section O "Special Treatments, Procedures, and Programs" revealed Resident #82 as being coded for hospice. The MDS prior to this was also a quarterly MDS, dated 3/8/22 and also coded the resident as being on hospice. However, further review of the MDS's revealed that the most recent significant change MDS was dated 12/6/21, before the resident was ordered hospice services. The resident was not coded on this MDS as being on hospice. There were no significant change MDS's completed to reflect the significant change of beginning admitted to hospice services, in conjunction with either the 12/22/21 hospice order or 4/1/22 hospice order.

On 6/29/22 at 9:30 AM, an interview was conducted with RN #1 (Registered Nurse) the MDS nurse. She stated that when a resident goes on or off of hospice services, a significant change MDS has to be done. She reviewed the clinical record and verified that it was not done.

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When asked about policies for completing the MDS, she stated the facility uses the RAI Manual.

A review of the RAI Manual (Resident Assessment Instrument) Version 1.17.1 dated October 2019, documented as follows:

On page 2-22, "Assessment Management Requirements and Tips for Significant Change in Status Assessments" and continued on page 2-23 was documented, "An SCSA is required to be performed when a terminally ill resident enrolls in a hospice program (Medicare-certified or State-licensed hospice provider) or changes hospice providers and remains a resident at the nursing home. The ARD must be within 14 days from the effective date of the hospice election (which can be the same or later than the date of the hospice election statement, but not earlier than). An SCSA must be performed regardless of whether an assessment was recently conducted on the resident. This is to ensure a coordinated plan of care between the hospice and nursing home is in place..."

On page O-5 was documented, "O0100: Special Treatments, Procedures, and Programs: O0100K, Hospice care - Code residents identified as being in a hospice program for terminally ill persons where an array of services is provided for the palliation and management of terminal illness and related conditions. The hospice must be licensed by the state as a hospice provider and/or certified under the Medicare program as a hospice provider..."

On 6/29/22 at approximately 1:00 PM, ASM #1 (Administrative Staff Member) the Executive Director, ASM #2 the Director of Nursing, and

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F 637	Continued From page 41 ASM #3 the Regional Director of Clinical Services, were made aware of the findings. No further information was provided by the end of the survey.	F 637		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview, resident interview, facility document review and clinical record review, it was determined the facility staff failed to complete an accurate MDS (minimum data set) assessment for one of 39 residents in the survey sample, Resident #90. The facility staff failed to complete an accurate annual assessment MDS for Resident #90. The findings include: Resident #90 was admitted to the facility on 9/6/19 with diagnoses that included but not limited to: paranoid schizophrenia, nicotine/cigarette dependence, arthritis and abnormal gait. Resident #90's most recent MDS, an annual assessment, with an assessment reference date of 3/29/22, coded the resident as scoring 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. MDS Section J1300- coded the resident as current tobacco use "no".	F 641	1. Resident #90's Annual Minimum Data Set with Assessment Reference Date of 3/29/22 was modified on 7/10/22 to reflect current smoking status in Section O. RN #1 was educated to ensure resident's smoking status is accurately coded on the MDS. 2. A quality review of residents who are active smokers was conducted on 7/10/22 to ensure smoking status was accurately coded on the most recent Comprehensive Minimum Data Set. Follow up based on finding. 3. Director of Nursing, or designee, to educate Minimum Data Set Coordinators to ensure resident smoking status is accurately coded on their Minimum Data Set. Unit Managers will be educated to notify the Minimum Data Set Coordinators in the daily clinical meeting of any change in resident smoking status so their Minimum Data Set section O can be coded correctly. 4. Director of Nursing/Unit Managers, to conduct Quality Monitoring review of residents who smoke weekly for 4 weeks then monthly for 2 months to ensure Section O of their Minimum Data Set is coded accurately. The Director of Clinical Services will reporting findings to the QAPI Committee and Quality Monitoring schedule will be modified based on findings.	8/3/2022

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A review of Resident #90's care plan dated 9/17/19 revealed the following, "FOCUS: Resident is a smoker. INTERVENTIONS: Instruct resident about smoking risks and hazards and about smoking cessation aids that are available. Instruct resident about the facility policy on smoking: locations, times, safety concerns."

A review of the smoking evaluations revealed that smoking evaluations had been completed for Resident #90 on 9/1/20, 12/1/20, 3/1/21, 11/24/21 and 3/3/22.

A review of the smoking evaluation dated 3/3/22 revealed, "Summary of Evaluation: Resident is determined to be a safe smoker."
On entrance a request was made for the smoking times and locations as well as a list of residents that smoke. The smoking times listed were 8-8:15 AM, 1:15-1:30 PM, 4-4:15 PM and 6:15-6:30 PM. Resident #90 was on the list.

Resident #90 was observed during the smoking time at 4:00 PM on 6/27/22.

An interview was conducted on 6/27/22 at 4:00 PM with Resident #90, when asked how long she has been smoking at the facility, Resident #90 stated, I have been smoking since I came here.

An interview was conducted on 6/29/22 at 9:25 AM with RN (registered nurse) #1, the MDS coordinator. When asked to review Resident #90's 3/29/22 MDS, RN #1 stated, "...tobacco use coded as no. I see that it was done by another coordinator, probably what she (MDS coordinator) did was look at the 7 day look-back period and she looked for documentation. There

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F 641	Continued From page 43 is hardly any progress notes, she would have looked for the safe smoking evaluation, but maybe didn't use it because it was outside of the 7 day window (3/3/22). I see it is on the care plan and dated 2019. I was not here, she probably just looked at progress notes. If I was coding this, I would have called the nurses after seeing smoking on the care plan. Technically no it is not accurate, she should have looked at the care plan." When asked what the standard is for the MDS coding, RN #1 stated, "We use the RAI (Resident Assessment Instrument) manual." On 6/29/22 at 12:40 PM, ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing and ASM #3, the Regional Director of Clinical Services were made aware of the above concerns. No further information was provided prior to exit.	F 641		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders.	F 655	1. Residents #301 and #303 had their current comprehensive care plan reviewed with them and were provided a copy with documentation in the medical record. Resident #299 no longer resides in the Center. LPN #4 was educated regarding completing a baseline care plan upon admission and reviewing the care plan with the resident's representative within 48 hours with documentation in the clinical record and providing a copy as indicated. 2. All new residents are at risk to be impacted by the alleged deficient practice. A quality review was conducted on residents admitted since 6/27/22 to ensure baseline care plan was completed, provided and reviewed with the resident representative with documentation in the clinical record.	8/3/2022

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F 655	Continued From page 44 (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview and clinical record review, it was determined that the facility staff failed to provide a written summary of the baseline care plan for 3 of 39 residents in the survey sample, Residents #301, #303 and #299. The findings include: 1. The facility staff failed to provide a written summary of Resident #301's (R301) baseline	F 655	Continued From page 44 3. Director of Clinical Services/Unit Managers to educate Licensed Nursing staff on completing baseline care plan upon admission, providing and reviewing a copy with the resident representative and scanning a signed copy into the medical record. Interdisciplinary team to review new admissions daily in Morning Meeting to ensure baseline care plan is completed and reviewed with the resident representative within 48 hours of admission with documentation in the medical record. 4. Director of Clinical Services/Assistant Director of Clinical Services to Conduct Quality Monitoring Review daily for 4 weeks then monthly for 2 months to ensure new admissions have baseline care plan completed, provided and reviewed with resident representative, and documented in the medical record. The Director of Clinical Services will reporting findings to the QAPI Committee and Quality Monitoring schedule will be modified based on findings.	8/3/2022

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care plan to the resident and/or the RR (resident's representative).

R301 was admitted to the facility on 4/20/22. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 4/27/22, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident is not cognitively impaired for making daily decisions.

A review of R301's clinical record revealed a baseline care plan dated 4/20/22. Further review of R301's clinical record (including the baseline care plan and progress notes since admission) failed to reveal documentation that R301 or the RR was provided a written summary of the baseline care plan or the baseline care plan.

On 6/28/22 at 2:30 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated the nurses complete baseline care plans on admission, review the care plans with residents or their representatives and have the residents or their representatives sign the care plans. LPN #4 stated residents/representatives are not routinely offered or provided a written summary of their baseline care plans or their actual baseline care plans but the baseline care plans are provided if requested.

On 6/28/22 at 4:19 p.m., an interview was conducted with R301. The resident stated a baseline care plan had not been provided.

On 6/28/22 at 5:40 p.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of nursing) were made aware of the above concern.

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The facility policy titled, "Plans of Care" documented information regarding the development of the baseline care plan but failed to document information regarding providing a written summary or the baseline care plan to the resident and/or the RR.

No further information was presented prior to exit.

2. The facility staff failed to provide a written summary of Resident #303's (R303) baseline care plan to the resident and/or the RR (resident's representative).

R303 was admitted to the facility on 6/24/22. An admission minimum data set assessment was not complete. An admission data collection dated 6/24/22 documented R303 was alert and oriented to person, place and time.

A review of R303's clinical record revealed a baseline care plan dated 6/24/22. Further review of R303's clinical record (including the baseline care plan and progress notes since admission) failed to reveal documentation that R303 or the RR was provided a written summary of the baseline care plan or the baseline care plan.

On 6/28/22 at 2:30 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated the nurses complete baseline care plans on admission, review the care plans with residents or their representatives and have the residents or their representatives sign the care plans. LPN #4 stated residents/representatives are not routinely offered or provided a written summary of their baseline care plans or their actual baseline care plans but the baseline care

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plans are provided if requested.

On 6/28/22 at 4:14 p.m., an interview was conducted with R303. The resident stated a baseline care plan had not been provided.

On 6/28/22 at 5:40 p.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of nursing) were made aware of the above concern.

No further information was presented prior to exit.

3. The facility staff failed to provide a written summary of Resident #299's (R299) baseline care plan to the resident and/or the RR (resident's representative).

R299 was admitted to the facility on 6/10/22. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 6/17/22, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident is not cognitively impaired for making daily decisions.

A review of R299's clinical record revealed a baseline care plan dated 6/10/22. Further review of R299's clinical record (including the baseline care plan and progress notes since admission) failed to reveal documentation that R299 or the RR was provided a written summary of the baseline care plan or the baseline care plan.

On 6/28/22 at 2:30 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated the nurses complete baseline care plans on admission, review the care plans with residents or their representatives and have the

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F 655	Continued From page 48 residents or their representatives sign the care plans. LPN #4 stated residents/representatives are not routinely offered or provided a written summary of their baseline care plans or their actual baseline care plans but the baseline care plans are provided if requested. R299 discharged from the facility on 6/28/22 and could not be interviewed. On 6/28/22 at 5:40 p.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of nursing) were made aware of the above concern. No further information was presented prior to exit.	F 655		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the	F 657	1.Resident #82 had his care plan updated on 06/26/22 to reflect his current hospice status. RN #1 was re-educated about ensuring the comprehensive care plan is updated in a timely manner to accurately reflect the resident's current status, including hospice services. 2. All residents on hospice services are at risk for being impacted by the alleged deficient practice. A quality review of hospice residents' comprehensive care plans to ensure they accurately reflect the resident's current status and plan of care. Follow up based on findings. 3. Director of Clinical Services to educate Minimum Data Sets Coordinators, Unit Managers, Activities, Dietary and Social Services about ensuring resident care plans are updated in a timely manner with changes and thoroughly reviewed during scheduled times.	8/3/2022

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F 657	Continued From page 49 resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to review and revise the comprehensive care plan for one of 39 residents in the survey sample; Resident #82. Resident #82 was admitted to hospice on 12/22/21. There was no revision to the comprehensive care plan to address the provision of and coordination with hospice services. The findings include: On the most recent MDS (Minimum Data Set) a quarterly assessment with an ARD (Assessment Reference Date) of 6/8/22, Resident #82 scored a 15 out of a possible 15 on the BIMS (Brief Interview for Mental Status) indicating the resident was cognitively intact in ability to make daily life decisions. The resident was coded as requiring supervision for eating and extensive to total care for all other areas of activities of daily living. A review of the clinical record revealed a physician's order dated 12/22/21 and rewritten again on 4/1/22 for hospice services. Further review of the clinical record revealed a	F 657	Continued From page 49 Interdisciplinary team to review resident changes during daily Clinical Meeting to ensure resident's care plan is updated in a timely manner to reflect their current status. 4. Director of Nursing/Assistant Director of Nursing to conduct Quality Monitoring Review of 10 residents daily for 4 weeks then monthly for 2 months to ensure changes to the plan of care are updated in a timely and accurate manner The Director of Clinical Services will reporting findings to the QAPI Committee and Quality Monitoring schedule will be modified based on findings.	8/3/2022

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nurse's note dated 12/22/21 that documented, "Resident admitted into [name of] Hospice, with Diagnosis: CHF (congestive heart failure) and COPD (chronic obstructive pulmonary disease). with NO (new orders): Hydrocodone / Acetaminophen (1) 7.5 mg (milligrams) /325 mg PO (by mouth) Q 6 hrs (every six hours) Around The Clock."

A review of the comprehensive care plan revealed one dated 8/6/21 and revised on 1/12/22 for "Resident has advanced directives r/t (related to) DNR (Do Not Resuscitate)." Interventions dated 8/6/21 and revised on 6/14/22 documented, "Discuss advanced directives with resident and or residents representative" and "Physician order for DNR." Neither this nor any other care plan addressed end of life care and the provision of and coordination with hospice services.

On 6/29/22 at 9:30 AM, an Interview was conducted with RN #1 (Registered Nurse) the MDS nurse. She stated that when a resident is on hospice, the comprehensive care plan has to be revised to address hospice services.

The facility policy, "Plans of Care" was reviewed. This policy documented, "Review, update and/or revise the comprehensive plan of care based on changing goals, preferences and needs of the resident and in response to current interventions after the completion of each OBRA MDS assessment (except discharge assessments), and as needed. The interdisciplinary team shall ensure the plan of care addresses any resident needs and that the plan is oriented toward attaining or maintaining the highest practicable physical, mental and psychosocial well-being."

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F 657	Continued From page 51 On 6/29/22 at approximately 1:00 PM, ASM #1 (Administrative Staff Member) the Executive Director, ASM #2 the Director of Nursing, and ASM #3 the Regional Director of Clinical Services, were made aware of the findings. No further information was provided by the end of the survey. (1.) Hydrocodone Acetaminophen - an opiate medication used to treat moderate to severe pain. Information obtained from https://medlineplus.gov/druginfo/meds/a601006.html	F 657		
F 730 SS=E	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on staff interview and employee record review, it was determined that the facility staff failed to ensure that 5 of 10 CNAs (certified nursing assistants) received annual performance reviews. The findings include: On 06/28/2022 a record review was conducted of the annual performance reviews of five CNAs. This review failed to evidence the annual performance reviews for the following CNAs:	F 730	1. Center identified that they are out of compliance with the yearly performance evaluations and annual competency evaluation for the employees. 2. All residents are at risk to be impacted by the alleged deficient practice. A quality review was conducted by Human Resources of employee files to determine if performance evaluations are out of compliance. Employees that were due for annual evaluation in the months of March, April, May and June will receive an evaluation and review of competencies from their supervisor. Human Resources to develop monthly list of employees that are due for 90 day or annual evaluation/review of competencies and notify the Executive Director and Director of Clinical Services. 3. Human Resources Coordinator to re-educate Executive Director and Department Heads about ensuring performance evaluations are completed after 90 day introductory period and annual, according to regulations	8/3/2022

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F 730	Continued From page 52 1. CNA # 3 - hire date 12/17/2019, no evidence of performance review between 12/17/2019 and 12/17/2020. 2. CNA # 4 - hire date 10/18/2019, no evidence of performance review between 10/18/2019 and 10/19/2020. 3. CNA # 5 - hire date 05/20/2019, no evidence of performance review between 05/20/2019 and 05/20/2020. 4. CNA # 6 - hire date 4/27/2018, no evidence of performance review between 04/27/2021 and 04/27/2022. 5. CNA # 7 - hire date 01/05/2017, no evidence of performance review between 01/05/2021 and 01/05/2022. On 06/29/2022 at approximately 1:05 p.m. an interview was conducted with ASM (administrative staff member) # 2, director of nursing and OSM (other staff member) # 8 director of human resources. When asked for the competency reviews for the CNAs listed above ASM # 2 stated that they did not have the competency reviews. When asked who was responsible for completing the competency reviews ASM # 2 stated that the unit managers were responsible for completing them due to the fact that they knew the CNAs. When asked to describe the procedure for the competency reviews OSM # 8 stated that the reviews were completed annually with the CNAs hire date as the anniversary date for completing the competency reviews. The facility's policy "Employee]=Job Performance Evaluations [sic]" documented in part, "Policy: It is the policy of The Company to evaluate each employee's job performance on a continual and ongoing basis. Employees will receive an evaluation of their performance prior to the	F 730	Continued From page 52 By the 5th of each month the Human Resources Coordinator will run a list of evaluations due for the month and provide the list to department heads to ensure evaluations and competencies are reviewed and updated as indicated. 4. Executive Director to conduct Quality Monitoring Review of 10 employee files weekly for 4 weeks then monthly for 2 months to ensure performance evaluations/competencies are completed per regulations. Identified Issues to be corrected. Findings to be report to QAPI. Quality Monitoring schedule to be modified based on findings.	8/3/2022

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F 730	Continued From page 53 completion of their Introductory Period and annually thereafter ... Written performance evaluations are to be prepared by the employee's immediate supervisor in conjunction with the department head, or in the absence of a supervisor, by the department head. All evaluations for facility employees must be reviewed and approved by the facility Executive Director prior to being reviewed with the employee. Anniversary Date: The anniversary of your start date is the date you should receive your formal review and performance evaluation, unless a job change has taken place. If a job change includes a change in compensation, you generally will be reviewed again one year from the date of the job change. If no compensation change takes place, you will retain your original review date." On 05/29/2022 at approximately 12:40 p.m., ASM # 1, executive director, ASM # 2, director of nursing and ASM # 4, regional director of clinical services, were made aware of the findings. No further information was presented prior to exit.	F 730		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the	F 756	1. Pharmacy recommendation for renal function panel for resident #62 was drawn and resulted 6/30/2022 with no further intervention required. 2. All residents at risk to be impacted by the alleged deficient practice. A quality review was conducted on all pharmacy medication recommendations done for the month of May and June of 2022 to ensure all were addressed.	8/2/2022

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F 756	Continued From page 54 facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to respond to a pharmacist's monthly medication review recommendation for one of 39 residents in the survey sample, Resident #62 (R62). The facility staff failed to follow up on the pharmacist recommendation to obtain blood tests to determine R62's kidney function.	F 756	Continued From page 54 3. Executive Director/Director of Clinical Services to educate unit manager on addressing pharmacy recommendations medication review on timely manner. Unit manager's email forwarded to pharmacy representative to ensure they are copied on all resident recommendation. Assistant Director of Clinical Services/Unit Managers will validate by the end of each month that all pharmacy recommendations have been reviewed and addressed as indicated by the medical team and follow up as indicated. 4. Executive Director/Director of Clinical Services will conduct pharmacy medication review on 10 percent of the residents monthly for 3 months, to ensure compliance. The Director of Clinical Services will report findings to the QAPI Committee monthly and Quality Monitoring Review schedule will be modified based on findings.	8/3/2022

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F 756	Continued From page 55	F 756		

The findings include:

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/18/22, R62 was coded as being severely impaired for making daily decisions, having scored 6 out of 15 on the BIMS (brief interview for mental status).

A review of the monthly medication regimen reviews for R62 revealed a review dated 5/27/22. The review documented: "[R62] has not had an assessment of renal (kidney) function within the past six months...Please monitor [blood tests to reveal kidney function] on the next convenient lab day and at least every six months thereafter."

Further review of R62's clinical record failed to reveal any laboratory tests ordered after the 5/27/22 medication regimen review.

Further review of R62's clinical record revealed the pharmacist had completed the June 2022 medication regimen review for R62 on 6/23/22.

On 6/28/22 at 5:40 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing, were informed of this concern.

On 6/29/22 at 9:23 a.m., ASM #2 stated there was no way to defend the lab test not being performed. She stated when the recommendations come from the pharmacy, either the director of nursing or the assistant director of nursing looks through them and takes items requiring an order to the physician. She stated she and the former director of nursing had both been out of work at the time this

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F 756	Continued From page 56 recommendation came from the pharmacist. She stated she had spoken with the physician and put in an order for the laboratory tests to be performed on R62 earlier in the morning. She stated the contract laboratory company performs residents' laboratory tests on regularly on Tuesdays and Thursdays, and at other requested times if urgent. A review of the facility policy, "Medication Regimen Review," revealed, in part: The pharmacist will address copies of residents' MRRs (medication regimen reviews) to the Director of Nursing and/or the attending physician and to the Medical Director...If an irregularity does not require urgent action but should be addressed before the consultant pharmacist's next monthly MRR, the facility staff and the consultant pharmacist will confer on the timeliness of attending physician responses to identified irregularities." No further information was provided prior to exit.	F 756		
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff	F 804	1. Meals served to Resident #34, Resident #37, and Resident #50 have been within the acceptable temperature limit, meal temperature are taken before sending out to the units. Food Service Manager educated dietary staff to ensure they are using plate warmer to maintain food temperature. 2. All the residents that receive a meal tray are at risk to be impacted by the alleged deficient practice. 3. Food Services Manager will educate dietary staff on the use of plate warmer in order to maintain the food temperature. An audit will be done by the Food Services Manager to ensure timely delivery of meal trays.	8/3/2022

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F 804	Continued From page 57	F 804	Continued From page 57	

Interview, facility document review and clinical record review, the facility staff failed to serve food at a palatable temperature for 3 of 39 residents in the survey sample, Residents #50, #34 and #37.

The findings include:

On Resident #50's (R50) most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/5/22, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident is not cognitively impaired for making daily decisions. On 6/27/22 at 1:42 p.m., an interview was conducted with R50 and the resident stated the facility food was cold.

On Resident #34's (R34) most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 4/21/22, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident is not cognitively impaired for making daily decisions. On 6/27/22 at 2:59 p.m., an interview was conducted with R34 and the resident stated the food was usually cold when served.

On Resident #37's (R37) most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 4/22/22, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident is not cognitively impaired for making daily decisions. On 6/27/22 at 3:13 p.m., an interview was conducted with R37 and the resident stated the facility food was cold.

On 6/28/22 at 1:02 p.m., a meal test tray was

4. Food Services Manager/food services assistant will audit 5 trays each week for 4 weeks then monthly for 2 months to ensure proper food temperature is maintained. Findings will be reported to the QAPI Committee monthly and Quality Monitoring Review schedule will be modified based on findings.

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ENVOY OF ALEXANDRIA, LLC	900 VIRGINIA AVENUE ALEXANDRIA, VA 22302

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 804	Continued From page 58 conducted as the last resident on the last unit was being served. The temperatures of the food were taken by OSM (other staff member) #4 (the food services manager) and read by OSM #4 and OSM #5 (the district food services manager). The pureed carrots were 98 degrees (Fahrenheit), the pureed bread was 110 degrees and the pureed fish was 100 degrees. The food was tasted by two surveyors, OSM #4 and OSM #5. OSM #4 stated the food, "could be hotter" and OSM #5 agreed. On 6/28/22 at 5:40 p.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, "Food Production/Preparation" documented, "Food will be prepared under sanitary condition as outlined in the most current FDA Food Code using methods that conserve nutritive value, quality, flavor and appearance." No further information was presented prior to exit.	F 804		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent	F 812	1. All the food items left in second floor nourishment room refrigeration beyond recommended best by date was discarded 6/28/22, staffs re-educated on facility policy on food storage. 2. All residents are at risk to be impacted by the alleged deficient practice. A quality review was conducted by the Dietary Manager and Unit Manager on all the nourishment room refrigerators to ensure that there were no expired items per the facility food policy.	8/3/2022

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F 812	Continued From page 59 facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(l)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, the facility staff failed to store food in a safe manner in 1 of 3 unit nourishment room refrigerators, the second floor nourishment room. The second floor nourishment room refrigerator contained multiple food items that were past the manufacturers' use by and best by dates. The findings include: On 6/28/22 at 2:10 p.m., observation of the second floor nourishment room refrigerator was conducted with LPN (licensed practical nurse) #4. The following was observed: one 2 pound block of sharp cheddar cheese with a best by date of 8/14/21, one 13 ounce can of whipped topping with a best by date of 12/25/21, one 6.5 ounce can of whipped topping with a use by date of 3/31/22, one 15 ounce bottle of creamy French dressing with a best if used by date of 10/5/21 and one ham and cheddar cracker stacks lunchable with a use by date of 9/4/21. At that time, an interview was conducted with LPN #4. LPN #4 stated the temperature of the refrigerator is supposed to be checked by a nurse every day and at that time, the nurse should check the food	F 812	Continued From page 59 3. Unit Managers/Dietary Manager will educate all staff regarding food storage, monitoring and discarding food per manufactural recommendation and facility policy. 4. Director of Clinical Services/Assistant Director of Clinical Services will conduct Quality Monitoring Review of nourishment room refrigerators for food storage and expiration dates to ensure no expired items are present 5 days a week for 4 weeks, then monthly, for 2 months, to ensure compliance. The Director of Clinical Services/Assistant Director of Clinical Services will report findings to the QAPI Committee monthly and Quality Monitoring Review schedule will be modified based on findings.	8/3/2022

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F 812	Continued From page 60 items to ensure nothing is past the use by or best if used by date. LPN #4 stated all of the above items should have been discarded and threw them in the trash. On 6/28/22 at 2:49 p.m., an interview was conducted with OSM (other staff member) #4 (the dietary manager). OSM #4 stated the dietary staff delivers snacks and juices to the unit nourishment rooms. OSM #4 stated the nurses primarily remove food items from the unit refrigerators but he does so if he is in the refrigerators and notices foods that are past the use by or best if used by date. On 6/28/22 at 5:40 p.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, "Food Storage: Cold Foods" documented, "All Time/Temperature Control for Safety (TCS) foods, frozen and refrigerated, will be appropriately stored in accordance with guidelines of the FDA Food Code." No further information was presented prior to exit.	F 812		
F 814 SS=F	Dispose Garbage and Refuse Properly CFR(s): 483.60(l)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, the facility staff failed to maintain the dumpsters in a sanitary manner for	F 814	1. Garbage Refuse Dumpsters will be used properly to ensure a sanitary and clean environment to diminish and repel any rodents, flies and or birds. 2. All residents are at risk for being impacted by the alleged deficient practice. A quality review was conducted of all dumpsters to ensure clean and secured. Environmental/Housekeeping Director and the Dietary Director have been educated by the Executive Director on the policy "Dispose of Garbage and Refuse" and as	8/3/2022

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F 814	Continued From page 61 two of two dumpsters containing trash. On 6/28/22, the sliding side doors of two dumpsters were observed open and multiple flies were inside the dumpsters. The findings include: On 6/28/22 at 2:48 p.m., an observation of the facility dumpsters was conducted. Two of two dumpsters containing trash were observed with both sliding side doors completely open. Multiple flies were inside the dumpsters. No staff was utilizing the dumpsters at this time. On 6/28/22 at 2:50 p.m., an interview was conducted with OSM (other staff member) #4 (the dietary manager). OSM #4 stated the side doors on the dumpsters are supposed to be closed so rodents, flies and birds aren't attracted to the area. On 6/28/22 at 2:58 p.m., an interview was conducted with OSM #7 (the housekeeping manager). OSM #7 stated the side doors on the dumpsters should be closed if staff is not dumping trash. OSM #7 stated rodents, flies and "anything" can crawl into the dumpsters. On 6/28/22 at 5:40 p.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, "Dispose of Garbage and Refuse" documented, "All garbage and refuse will be collected and disposed of in a safe and efficient manner."	F 814	Continued From page 61 such all garbage and refuse will be collected and disposed of in a safe and including properly closing the lid and or side doors of the dumpsters after every use. 3. Executive Director will educate all dietary and maintenance staff on cleanliness and security of the dumpster. The Environmental Director will monitor the dumpster area ensuring lids fully closed and secured and area is clean. 4. Executive Director will conduct quality monitoring audits weekly for 4 weeks then monthly for 2 months to ensure the dumpster lids are closed and the area is clean The DCS will report findings to the QAPI Committee monthly and Quality Monitoring Review schedule will be modified based on findings.	8/3/2022

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F 814	Continued From page 62 No further information was presented prior to exit.	F 814		
F 840 SS=D	Use of Outside Resources CFR(s): 483.70(g)(1)(2) §483.70(g) Use of outside resources. §483.70(g)(1) If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or an agreement described in paragraph (g)(2) of this section. §483.70(g)(2) Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for- (i) Obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and (ii) The timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to evidence a current dialysis contract between the facility and the outpatient dialysis center providing services for one of 39 residents in the survey sample, Resident #85. The findings include: On Resident #85's (R85) most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of	F 840	1. Resident #85 no longer resides at the center. On 06/30/2022 dialysis contract was signed by Fresenius Medical Care of North America. 2. All residents on dialysis are at risk to be impacted by the alleged deficient practice. A quality review was conducted by the Executive Director to ensure that all dialysis facilities being used by our residents have an active contract with the facility. 3. Executive Director/Director of Clinical Services will educate admission staff on ensuring that the facility has a standing contract for any dialysis patient before accepting them. The Unit Managers will notify the Executive Director when any resident is going to be initiating dialysis so the facility can ensure that an active contract is in place. 4. Executive Director will conduct an audit on all admitted/newly ordered dialysis residents monthly for 3 month to ensure compliance. Findings will be reported to the QAPI Committee monthly and Quality Monitoring Review schedule will be modified based on findings.	8/3/2022

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F 840	Continued From page 63	F 840		

6/9/22, the resident scored 13 out of 15 on the BIMS (brief interview for mental status), indicating the resident is not cognitively impaired for making daily decisions.

An admission notification form dated 5/20/22 documented R85 required dialysis. A review of R85's clinical record revealed a physician's order dated 6/21/22 for dialysis every Monday, Wednesday and Friday. A review of the facility dialysis contracts failed to reveal a contract for R85's dialysis provider.

On 6/28/22 at 12:12 p.m., ASM (administrative staff member) #2 (the director of nursing) provided a letter addressed to ASM #1 (the executive director) and dated 6/28/22. The letter documented, "(R85) (a mutual client) has been receiving dialysis with (name of dialysis center) since June 5, 2022. In anticipation of other patients from (name of facility) requiring dialysis treatments, a request for a Long-Term Care Facility Outpatient Agreement to the (name of dialysis center) paralegal team has been submitted by (name of dialysis center administrator)..."

On 6/28/22 at 5:38 p.m. an interview was conducted with ASM #1. ASM #1 stated a contract R85's dialysis center was not established until this date. ASM #1 stated he went to the dialysis facility on this date and received the above letter. ASM #1 stated an agreement should be received on the next date.

On 6/28/22 at 5:40 p.m., ASM #1 and ASM #2 were made aware of the above concern.

On 6/29/22 at approximately 11:47 a.m., ASM #1

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F 840	Continued From page 64 stated a contract with R85's dialysis center had been developed. The facility policy titled, "Coordination of Hemodialysis Services" documented, "Residents requiring an outside ESRD (end stage renal disease) facility will have services coordinated by the facility. There will be communication between the facility and the ESRD facility regarding the resident. The facility will establish a Dialysis Agreement/Arrangement if there are any residents requiring Dialysis Services. The agreement shall include how the residents care is to be managed." No further information was presented prior to exit.	F 840		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized	F 842	1. Nursing staff on the unit re-educated on proper 1:1 supervision documentation paperwork by writing OOF(out of facility) instead of initialing their name evidence by documentation presented for resident #37 on days he was out of the facility due to chest pain. 2. All residents in the facility are at risk to be impacted by the alleged deficient practice. A quality review was conducted to ensure that any resident on 1:1 supervision had accurate documentation in their medical record. 3. Director of Clinical Services/Unit Managers will re-educate direct care staffs regarding proper and accurate documentation for 1:1 supervision observation to ensure accuracy in transmission of medical record.	8/3/2022

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F 842	Continued From page 65 §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening	F 842	Continued From page 65 Unit Managers will notify the interdisciplinary team when a situation arises that requires a resident to be placed on 1:1 supervision so that the appropriate staff can be notified and documentation requirements discussed and reviewed. 4. Director of Clinical Services/Assistant Director of Clinical Services will conduct Quality Monitoring Review of residents who are placed 1:1 observation daily for 3 x a week for 4 weeks, then monthly, for 2 months. The Director of Clinical Services will report findings to the QAPI Committee monthly and Quality Monitoring Review schedule will be modified based on findings.	

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and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on resident interview, staff interview, facility document review and clinical record review it was determined that the facility staff failed to maintain a complete and accurate medical record for one of 39 residents in the survey sample, Resident #37.

The findings include:

Resident #37's (R37) most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 4/2/2022, the resident scored 15 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident is cognitively intact for making daily decisions.

On 6/27/2022 at 1:56 p.m., an interview was conducted with R37 in their room. R37 was observed to have a staff member sitting outside of the room in a chair monitoring the room. R37 stated that the previous Friday they had a fight with another resident who lived across the hall and now a staff member sat outside their door and went with them whenever they went outside to smoke. R37 stated that they had been in the hospital recently for chest pains.

The progress notes for Resident #37 documented in part:
- "5/24/2022 06:33 (6:33 a.m.) Note Text: [Name

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of R37] was admitted on 5/23/2022..."
- "5/22/2022 11:07 (11:07 a.m.) Note Text: Resident is in Hospital."
- "5/21/2022 14:09 (2:09 p.m.) Note Text: Resident complained of chest Pain on left side with pain score of 9/10 at around 9:35am. Stated he has been having intermittent chest pain for about a week , stated that he did not tell any staff thought it will go away but pain is worse . Percocet 5/325mg 1 tab (tablet) given at 9:40 am. Supervisor notified. [Name of Physician] notified at 9:45, order to transfer Resident to ER (emergency room) for further evaluation. Resident transferred to ER at [Name of Hospital] at 10:30 am. all scheduled am (morning) medications administered prior to transfer. Report called in to [Name of staff] at 10:35am. Call placed to ER to check on Status of Resident, spoke to [Name of staff] was told Resident has been admitted for Chest pain."
- "5/3/2022 18:13 (6:13 p.m.) ... Resident currently in room alone with 1:1 (one to one) supervision to ensure safety of those around him. Resident's guardian and physician updated on current status."

On 6/28/2022 at 1:10 p.m., a request was made to ASM (administrative staff member) #2, the director of nursing, for any 1 to 1 documentation for R37 from 5/2/2022 through the present.

On 6/27/2022 at 3:22 p.m., an interview was conducted with OSM (other staff member) #6, admission coordinator. OSM #6 was observed outside of R37's room in a chair. OSM #6 stated that they were assigned 1 to 1 monitoring for the day. OSM #6 stated that they knew that R37 had been on 1 to 1 since the other resident returned from the hospital but they were not sure when

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that was. OSM #6 stated that they did not know who the other resident was but knew they were in another room. OSM #6 stated that they were observing R37 for any aggressive behaviors or abusive behaviors. OSM #6 stated that R37 was able to leave the room but they escorted them wherever they went and they were not allowed to go to smoke with the other residents. OSM #6 stated that they completed documentation of the 1 to 1 monitoring on paper forms kept in a binder every 15 minutes.

On 6/28/2022 at 11:05 a.m., an interview was conducted with OSM (other staff member) #10, the director of social services . OSM #10 stated that R37 had been on 1 to 1 monitoring since the resident to resident altercation on 6/24/2022. OSM #10 stated that they knew R37 was on 1 to 1 monitoring prior to that incident but was not sure of the timeframe.

On 6/28/2022 at 12:54 p.m., an interview was conducted with LPN (licensed practical nurse) #7. LPN #7 stated that R37 was on 1 to 1 monitoring and had a chaperone if they left the room since the altercation on 6/24/2022. LPN #7 stated that the 1 on 1 monitoring was off and on based on behaviors for residents and they were informed when to stop by the director of nursing. LPN #7 stated that they documented the 1 to 1 monitoring on paper sheets every 15 minutes.

On 6/28/2022 at 2:11 p.m., an interview was conducted with ASM (administrative staff member) #2, the director of nursing. ASM #2 stated that R37 was competent and had been to court to have the guardianship lifted. ASM #2 stated that R37 had previously damaged a facility laptop when the nurse would not give them

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additional pain medications. ASM #2 stated that the police had come at that time and R37 had lied to the police saying they did not remember anything. ASM #2 stated that R37 did not lack capacity and the police knew they were lying but could not do anything. ASM #2 stated that the previous DON (director of nursing) had moved R37 to a private room and placed them on 1 to 1 monitoring at that time and there had been no further behaviors. ASM #2 stated that they had ended the 1 to 1 monitoring around 5/24/2022 because R37 was not displaying any behaviors and the physician had determined that it could be lifted. ASM #2 stated that they were having the physician fax over a note documenting this. ASM #2 stated that they were gathering the requested documentation regarding the 1 to 1 monitoring.

On 6/28/2022 at approximately 4:15 p.m., ASM #2 provided 1 to 1 monitoring documentation titled "Resident Safety Check" and a copy of a prescription dated 5/24/22 for R37 which documented, "D/C (discontinue) sitter, patient has been cooperative. No signs of him being risk to others."

Review of the "Resident Safety Check" documents provided evidenced 15 minute checks completed 5/2/2022-5/24/2022 and 6/24/2022-6/27/2022. Further review of the safety checks documented 15 minute checks completed on 5/21/2022 from 10:30 a.m. through 5/22/2022 at 4:00 p.m. and 5/22/2022 7:00 p.m.-11:45 p.m. The clinical record documented R37 being admitted to the hospital on 5/21/2022 after leaving at 10:30 a.m. and readmitting to the facility on 5/23/2022. The clinical record failed to evidence a readmission time on 5/23/2022, however the "Resident Safety Check" document

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evidenced 15 minute safety checks starting at 12:00 a.m. on 5/23/2022.

On 6/29/2022 at 10:08 a.m., an interview was conducted with ASM #5, medical doctor. ASM #5 stated that they care for R37. ASM #5 stated they saw R37 on 5/24/2022 and discontinued the 1 to 1 sitter. ASM #5 stated that they did not write a note in the medical record because it was a quick visit and they just "eyeballed" R37. ASM #5 stated that their normal practice was to document anything that was a significant change or needed a note. ASM #5 stated that the DON had asked for a note and they had written the prescription that was faxed over and had taken it back to their hospital based office to be placed in a file. ASM #5 stated that they were sure that it had been faxed to the facility prior to 6/28/2022 to be in the medical record, but the DON had asked them to resend it. ASM #5 stated that they based the discontinuing of the 1 to 1 monitoring on their observation at that time and currently R37 needed 1 to 1 monitoring until they could be safely discharged.

On 6/29/2022 at 11:19 a.m., an interview was conducted with ASM #2, director of nursing. ASM #2 stated that R37's 1 to 1 monitoring was discontinued on 5/24/2022 when they asked the physician to stop it because the nurses notes showed that they were compliant and had no behaviors. ASM #2 stated that the note from the physician dated 5/24/2022 should be a part of the medical record. ASM #2 stated that their medical records staff person had been out and things were behind. ASM #2 stated that they had looked for the note in medical records and were not able to find anything so they had asked the physician to send it over. ASM #2 was asked about the

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"Resident Safety Check" documentation for R37 provided which documented checks every 15 minutes on 5/21/2022 after R37 had transferred to the emergency room, and every 15 minutes on 5/22/2022 with the exception of 4:15 p.m.-6:45 p.m. when they were admitted to the hospital. ASM #2 stated that they would have to validate the safety checks for those days.

On 6/29/2022 at 12:34 p.m., ASM #2 stated that they had reviewed the safety checks for R37 for 5/21/2022 and 5/22/2022. ASM #2 stated that they had spoken with the staff to find out what they meant and it appeared to be a lack of education on how to document on the form. ASM #2 stated that staff were initialing the form rather than writing OOF (out of facility) on the form and also not documenting the residents information on the form. ASM #2 stated that the form should have the residents name and the record was not accurate and the organization of the documentation needed to be corrected.

The facility policy "Clinical/Medical Records" with a revision date of 8/25/2017 documented in part, "...Clinical records are maintained in accordance with professional practice standards to provide complete and accurate information on each resident for continuity of care. The purpose of the clinical record is to document the course of the resident's plan of care and to provide a medium of communication among health care professionals involved in this care..."

On 6/29/2022 at 12:55 p.m., ASM #1, the executive director, ASM #2, the director of nursing and ASM #4, the regional director of clinical services were made aware of the findings.

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F 842	Continued From page 72 No further information was provided prior to exit.	F 842		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the	F 883	1. Resident #56's responsible party was called to get consent and educated of the benefit of pneumococcal vaccination due to R#56 age, verbal consent given for the administration of the vaccine. Vaccine order and administered to Resident #56. 2. All residents at risk for being impacted by the alleged violation. A quality review of residents' pneumococcal vaccine status was completed and pneumococcal vaccine was offered if indicated. 3. Director of Clinical Services/Unit Managers will educate nursing staff on the policy of pneumococcal vaccines. They will be educated to obtain information upon admission and ensuring that /declination forms are obtained and placed into the medical record. 4. Director of Clinical Services/Unit Managers to complete a Quality monitoring audit on all new admits and pneumococcal status weekly for 4 weeks then monthly for 2 months, to ensure compliance. The Director of Clinical Services will report findings to the QAPI Committee monthly and Quality Monitoring Review schedule will be modified based on findings.	8/3/2022

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immunization;
(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and
(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, it was determined that the facility staff failed to offer, obtain consent and/or provide education regarding the pneumococcal vaccines for one of five residents in the immunization record review, Residents # 56 (R56).

The findings include:

The facility staff failed to offer, obtain consent and provide education regarding the pneumococcal vaccines for (R56).

On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 05/11/2022, the resident was coded as having both short and long term memory difficulties and was coded as being severely cognitively impaired for making

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daily decisions. Under Section "O Special Treatments, Procedures and Programs" (R56) was coded as not being offered the pneumococcal vaccine.

A review of the (R56's) clinical record and EHR [electronic health record] failed to evidence that the pneumococcal vaccine was offered and consent and education was provided.

On 06/29/2022 at approximately 8:22 a.m., an interview was conducted ASM (administrative staff member) # 2, director of nursing. When asked about the documentation for (R56's) pneumococcal vaccine ASM # 2 stated that the RN (registered nurse) had spoken to (R56's) family and the family declined the vaccine. ASM # 2 further stated that the consent and education was not completed or signed and was scanned into (R56's) the electronic health record blank.

On 06/29/2022 at approximately 11:10 a.m., an interview was conducted ASM # 2, director of nursing. When asked to describe the process for the pneumococcal vaccine ASM # 2 stated that upon a resident's admission to the facility they offer information about the vaccine to the resident and/or family. If the resident had received the vaccine before coming into the facility they document the information in the EHR (electronic health record) for the resident. ASM # 2 stated if the resident or family declines the vaccine it's documented on the facility's "Informed Consent For Pneumococcal Vaccine", given to medical records and scanned into the resident's EHR. When asked if information regarding the vaccine and vaccine were offered to (R56) since there was a lack of document ASM # 2 stated no.

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F 883	Continued From page 75 The facility's policy "Pneumococcal Vaccine" documented in part, "1. Prior to or upon admission, residents will be assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, will be offered the vaccine series within thirty (30) days of admission to the facility unless medically contraindicated or the resident had already been vaccinated...3. Before receiving a pneumococcal vaccine, the resident or legal representative shall receive information and education regarding the benefits and potential side effects of the pneumococcal vaccine." On 06/29/2022 at approximately 12:40 p.m., ASM (administrative staff member) # 1, executive director, ASM # 2, director of nursing and ASM # 4, regional director of clinical services, were made aware of the findings. No further information was presented prior to exit.	F 883		
F 909 SS=E	Resident Bed CFR(s): 483.90(d)(3) §483.90(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible. This REQUIREMENT is not met as evidenced by: Based on staff interview, resident interview, facility document review and clinical record review, it was determined the facility staff failed to evidence bed inspection for risk of entrapment for	F 909	1. All four residents identified in the survey (Resident#16, Resident #66, Resident #96 and Resident #45) have had their bed safety check completed for risk of entrapment, including bed mattress/frame compatibility, bed rails usage and side rails usage for safety, security and well-being for the residents.. 2. All residents are at risk for being impacted by the alleged deficient practice. A quality review of all beds was completed to ensure proper functioning. They will have their bed safety check completed on a quarterly basis and upon admission, accordingly. This will include inspection of mattresses, bed compatibility, side rails and bed rails usage for safety and security, free from any possibility of entrapment.	8/3/2022

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F 909	Continued From page 76 4 of 39 residents in the survey sample, Resident #16, Resident #66, Resident #96 and Resident #45. 1. The facility staff failed to inspect Resident #16's bed for risk of entrapment. Resident #16 was admitted to the facility on 6/15/16 with diagnoses that included but were not limited to: psychotic disorder and anxiety disorder. Resident #16's most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 3/20/22, coded the resident as scoring 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. MDS Section G- Functional Status, coded the resident as requiring extensive assistance in bed mobility and transfers. Observation of Resident #16 resting in bed on 6/27/22 at 1:45 PM, 6/28/22 at 10:00 AM and 6/29/22 at 8:30 AM. 1/4 side rails were observed to be in use. On 6/27/22 at 5:00 PM, a request was made for evidence of the documentation of the annual bed safety inspection for the entire facility. There was no evidence of the requested documentation for Resident #16. The physician's order dated 7/28/20, revealed the following, "Side Rails: 1/4 side rails for bed mobility and positioning." A review of the side rail evaluation dated 10/23/21, revealed the following, "Bed mobility:	F 909	Continued From page 76 3. Executive Director will educate Maintenance Director to audit beds on admission, quarterly and as indicated with any issues. Any issues will be addressed immediately and reported to ED for follow up. Executive Director and Director of Clinical Services will notify the maintenance supervisor/assistant in daily clinical meeting of new or pending admits for bed inspections to be completed. These will be added to an inspection log to be kept by the maintenance team and used for quarterly bed inspection tracking. 4. Executive Director to complete a Quality monitoring audit to review 10 beds per week for 4 weeks then monthly for 2 months to ensure proper functioning and equipment use. The Director of Clinical Services will report findings to the QAPI committee monthly and Quality Monitoring Review schedule will be modified based on findings.	8/3/2022

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will the bed rail (s) assist the resident in turning side to side/holding self to one side? Yes. Will the bed rail (s) assist the resident in moving up and down in bed? Yes. Will the bed rail (s) assist the resident in pulling self from lying to sitting position? Yes. Recommendations: Side rails recommended."

A review of Resident #16's care plan dated 6/28/19 revealed the following, "FOCUS: has an ADLs (activities of daily living)elf-care performance deficit related to General debility, Muscle wasting, Limited Mobility, Contractures of lower extremities INTERVENTIONS: Quarter Side rails for bed mobility & positioning."

An interview was conducted on 6/27/22 at 1:45 PM with Resident #16. When asked if the resident used the side rails, Resident #16 stated, "Yes, I use them to help move in bed."

An interview was conducted on 6/28/22 at 2:40 PM with OSM (other staff member) #2, the maintenance technician. When asked for the evidence of the annual bed safety inspection, OSM #2 stated, no, there is nothing in TELS (team electronic library system) for all beds. When asked what was checked on the beds, OSM #2 stated, we look at the side rails every week, but we do not track the bed rails. The previous director told me everything was in the computer and to not worry about tracking anything on paper. When asked if OSM #2 was given specific room and bed numbers, could a report of inspection for that bed be ran, OSM #2 stated, no, there is no report for specific beds. When asked for the manufacturer's recommendation for checking the side rails, OSM #2 stated, no I do not have that information.

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When asked how OSM #2 was checking bed rails per the manufacturers, OSM #2 stated, I am not sure, this is my first time seeing this policy. OSM #2 stated, this is all the information I have as we were provided a "TELS Logbook Documentation form which revealed the following: "Beds & Mattresses: Inspect Bed Rails: Maintenance Check: Inspect connectors on rails and tighten as necessary. Remove any burs or rough edges to prevent injury. Verify the function on the spring latch-knob assembly, if applicable. Ensure the latch is free of dirt and/or foreign material that could impair its function. Ensure that the rails engage and lock as specified. Tighten, adjust or replace any parts such as end caps, knobs, bolts, screws, etc., that are loose, show signs of wear or are missing."

The facility policy, "Side Rail/Bed Rail" was reviewed. This policy documented, "Policy: The Center, will attempt alternative interventions, and document in the medical record, prior to the use of side rail/bed rail. Side rail/bed rail may include but not limited to: Side rails, bed rails, safety rails, grab bars and assist bars. Procedure: 1. prior to installation of a side rail/bed rail complete the side rail/bed rail evaluation to evaluate the resident for risk of entrapment. 2. Review the risk and benefits with the resident and/or resident representative. 3. Obtain consent from the resident and/or resident representative. 4. Obtain physician order for side rail/bed rail. 5. Update the care plan and kardex. 6. Re-evaluate the use of side rail/bed rail, quarterly, with a change in condition or as needed. 7. Follow the manufacturers' recommendations and specifications for installing and maintaining side rails/bed rails."
The policy did not address routine or periodic

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maintenance and inspections of side rails and beds. The facility did not have a manual of the manufacturer's recommendations and specifications for the side rails. The facility was not logging and tracking routine or periodic bed and side rail inspections.

On 6/29/22 at 12:40 PM, ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing and ASM #3, the Regional Director of Clinical Services were made aware of the above concerns.

No further information was provided prior to exit.

2. The facility staff failed to inspect Resident #66's bed for risk of entrapment.

Resident #66 was admitted to the facility on 4/24/29 with diagnoses that included but were not limited to: multiple sclerosis.

Resident #66's most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 3/20/22, coded the resident as scoring 13 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. MDS Section G- Functional Status, coded the resident as requiring extensive assistance in bed mobility; total dependence for transfers.

Observation of Resident #66 resting in bed on 6/27/22 at 1:40 PM, 6/28/22 at 9:45 AM and 6/29/22 at 8:25 AM. 1/4 side rails were observed to be in use.

On 6/27/22 at 5:00 PM, a request was made for evidence of the documentation of the annual bed

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safety inspection for the entire facility. There was no evidence of the requested documentation for Resident #66.

The physician's order dated 7/28/20, revealed the following, "Side Rails: 1/4 side rails for bed mobility and positioning."

A review of the side rail evaluation dated 10/23/21, revealed the following, "Bed mobility: will the bed rail (s) assist the resident in turning side to side/holding self to one side? Yes. Will the bed rail (s) assist the resident in moving up and down in bed? Yes. Will the bed rail (s) assist the resident in pulling self from lying to sitting position? Yes. Recommendations: Side rails recommended."

A review of Resident #66's care plan dated 11/8/ daily living) self-care performance deficit related to MS (multiple sclerosis), wheelchair bound she prefers 18 revealed the following, "FOCUS: has an ADL (activities of to wear hospital gown despite having clothing from home. INTERVENTIONS: Bilateral quarter bed rails for mobility and reposition."

An interview was conducted on 6/27/22 at 1:35 PM with Resident #66. When asked if the resident used the side rails, Resident #66 stated, "Oh yes, I use them to help myself turn and get repositioned."

An interview was conducted on 6/28/22 at 2:40 PM with OSM (other staff member) #2, the maintenance technician. When asked for the evidence of the annual bed safety inspection, OSM #2 stated, No, there is nothing in TELS (team electronic library system) for all beds.

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When asked what was checked on the beds, OSM #2 stated, we look at the side rails every week, but we do not track the bed rails. The previous director told me everything was in the computer and to not worry about tracking anything on paper. When asked if OSM #2 was given specific room and bed numbers, could a report of inspection for that bed be ran, OSM #2 stated, no, there is no report for specific beds. When asked for the manufacturer's recommendation for checking the side rails, OSM #2 stated, no I do not have that information. When asked how OSM #2 was checking bed rails per the manufacturers, OSM #2 stated, I am not sure, this is my first time seeing this policy. OSM #2 stated, this is all the information I have as we were provided a "TELS Logbook Documentation form which revealed the following: "Beds & Mattresses: Inspect Bed Rails: Maintenance Check: Inspect connectors on rails and tighten as necessary. Remove any burs or rough edges to prevent injury. Verify the function on the spring latch-knob assembly, if applicable. Ensure the latch is free of dirt and/or foreign material that could impair its function. Ensure that the rails engage and lock as specified. Tighten, adjust or replace any parts such as end caps, knobs, bolts, screws, etc., that are loose, show signs of wear or are missing."

The facility policy, "Side Rail/Bed Rail" was reviewed. This policy documented, "Policy: The Center, will attempt alternative interventions, and document in the medical record, prior to the use of side rail/bed rail. Side rail/bed rail may include but not limited to: Side rails, bed rails, safety rails, grab bars and assist bars. Procedure: 1. prior to installation of a side rail/bed rail complete the side rail/bed rail evaluation to evaluate the

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	495203	A. BUILDING _____ B. WING _____	C 06/29/2022

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resident for risk of entrapment. 2. Review the risk and benefits with the resident and/or resident representative. 3. Obtain consent from the resident and/or resident representative. 4. Obtain physician order for side rail/bed rail. 5. Update the care plan and kardex. 6. Re-evaluate the use of side rail/bed rail, quarterly, with a change in condition or as needed. 7. Follow the manufacturers' recommendations and specifications for installing and maintaining side rails/bed rails."
The policy did not address routine or periodic maintenance and inspections of side rails and beds. The facility did not have a manual of the manufacturer's recommendations and specifications for the side rails. The facility was not logging and tracking routine or periodic bed and side rail inspections.

On 6/29/22 at 12:40 PM, ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing and ASM #3, the Regional Director of Clinical Services were made aware of the above concerns.

No further information was provided prior to exit.

3. The facility staff failed to inspect Resident #96's bed for risk of entrapment.

Resident #96 was admitted to the facility on 10/24/18 with diagnoses that included but were not limited to: morbid obesity and fibromyalgia.

Resident #96's most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 6/18/22, coded the resident as scoring 15 out of 15 on the BIMS (brief interview for mental status) score, indicating

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the resident was cognitively intact. MDS Section G- Functional Status, coded the resident as requiring extensive assistance in bed mobility and transfers.

Observation of Resident #96 revealed the resident was resting in bed on 6/27/22 at 1:30 PM, 6/28/22 at 9:15 AM and 6/29/22 at 8:15 AM. Grab bars/assist rails bilateral were observed to be in use.

On 6/27/22 at 5:00 PM, a request was made for evidence of the documentation of the annual bed safety inspection for the entire facility. There was no evidence of the requested documentation for Resident #96.

The physician's order dated 10/19/21, revealed the following, "Grab bars/assist rails bilateral to aid in bed mobility and repositioning."

A review of the side rail evaluation dated 1/26/22, revealed the following, "Bed mobility: will the bed rail (s) assist the resident in turning side to side/holding self to one side? Yes. Recommendations: Assist rail/grab bar recommended."

A review of Resident #96's care plan dated 11/1/18 revealed the following, "FOCUS: ADL (activities of daily living) self-care performance deficit related to debility, knee pain and fibromyalgia. INTERVENTIONS: Side rails: ¼ rails to aid in bed mobility."

An interview was conducted on 6/27/22 at 1:30 PM with Resident #96. When asked if the resident used the side rails, Resident #96 stated, "Yes, I use them to help turn in bed."

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An interview was conducted on 6/28/22 at 2:40 PM with OSM (other staff member) #2, the maintenance technician. When asked for the evidence of the annual bed safety inspection, OSM #2 stated, No, there is nothing in TELS (team electronic library system) for all beds. When asked what was checked on the beds, OSM #2 stated, we look at the side rails every week, but we do not track the bed rails. The previous director told me everything was in the computer and to not worry about tracking anything on paper. When asked if OSM #2 was given specific room and bed numbers, could a report of inspection for that bed be ran, OSM #2 stated, no, there is no report for specific beds. When asked for the manufacturer's recommendation for checking the side rails, OSM #2 stated, no I do not have that information. When asked how OSM #2 was checking bed rails per the manufacturers, OSM #2 stated, I am not sure, this is my first time seeing this policy. OSM #2 stated, this is all the information I have as we were provided a "TELS Logbook Documentation form which revealed the following: "Beds & Mattresses: Inspect Bed Rails...Maintenance Check: Inspect connectors on rails and tighten as necessary. Remove any burs or rough edges to prevent injury. Verify the function on the spring latch-knob assembly, if applicable. Ensure the latch is free of dirt and/or foreign material that could impair its function. Ensure that the rails engage and lock as specified. Tighten, adjust or replace any parts such as end caps, knobs, bolts, screws, etc., that are loose, show signs of wear or are missing."

The facility policy, "Side Rail/Bed Rail" was reviewed. This policy documented, "Policy: The

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Center, will attempt alternative interventions, and document in the medical record, prior to the use of side rail/bed rail. Side rail/bed rail may include but not limited to: Side rails, bed rails, safety rails, grab bars and assist bars. Procedure: 1. Prior to installation of a side rail/bed rail complete the side rail/bed rail evaluation to evaluate the resident for risk of entrapment. 2. Review the risk and benefits with the resident and/or resident representative. 3. Obtain consent from the resident and/or resident representative. 4. Obtain physician order for side rail/bed rail. 5. Update the care plan and kardex. 6. Re-evaluate the use of side rail/bed rail, quarterly, with a change in condition or as needed. 7. Follow the manufacturers' recommendations and specifications for installing and maintaining side rails/bed rails."
The policy did not address routine or periodic maintenance and inspections of side rails and beds. The facility did not have a manual of the manufacturer's recommendations and specifications for the side rails. The facility was not logging and tracking routine or periodic bed and side rail inspections.

On 6/29/22 at 12:40 PM, ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing and ASM #3, the Regional Director of Clinical Services were made aware of the above concerns.

No further information was provided prior to exit.

4. Resident #45 was observed in bed with bilateral half length side rails up bilaterally on 6/27/22 at 2:30 PM. The facility was not able to evidence that any bed inspections were done to ensure the safety of the side rails.

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On the most recent MDS (Minimum Data Set), a quarterly assessment with an ARD (Assessment Reference Date) of 4/27/22, Resident #45 scored a 13 out of a possible 15 on the BIMS (Brief Interview for Mental Status). The resident was coded as requiring supervision for eating and extensive to total care for all other areas of activities of daily living.

On 6/27/22 at 2:30 PM, Resident #45 was observed in bed with bilateral half length side rails up bilaterally.

A review of the clinical record revealed a physician's order dated 2/10/21 for "Bilateral 1/4 side rails to aid in positioning and mobility."

Further review of the clinical record revealed side rail assessments completed on 2/10/21, 3/9/21, 4/28/21, 7/21/21, and 10/21/21.

An "Informed Consent for Use of Bed Rails" was completed on 2/10/21.

A review of the comprehensive care plan revealed one dated 10/2/18 for "[Resident #45] has an ADL (activities of daily living) self-care performance deficit r/t (related to) aging process, Arthritis and limited mobility." This care plan included an intervention dated 10/2/18 and revised on 2/10/21 for "SIDE RAILS: Bilateral 1/4 side rails to aid in positioning and mobility."

On 6/28/22 at 2:41 PM, an interview was conducted with OSM #2 (Other Staff Member) the Maintenance Technician. She stated that she checks for side rail and bed safety. She stated that she does not log or track bed and side rail

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inspections and what components were inspected and what bed and/or room number and date of inspection. When asked about a manufacturer's manual for recommendations and specifications, she stated that she does not have one. She stated that she has not had a maintenance director for about 6 months and was told not to worry about anything on paper, just follow what is in the electronic maintenance system.

OSM #2 then provided a print out from the facility's electronic maintenance system. A review of this facility document revealed instructions for how to conduct bed and side rail inspections but still did not evidence that any actual inspections of any beds or dates of inspections. It also did not address the frequency of conducting the inspections. This document, "Beds & Mattresses: Inspect Bed Rails" documented, "....Maintenance Check: Inspect connectors on rails and tighten as necessary. Remove any burs or rough edges to prevent injury. Verify the function on the spring latch-knob assembly, if applicable. Ensure the latch is free of dirt and/or foreign material that could impair its function. Ensure that the rails engage and lock as specified. Tighten, adjust or replace any parts such as end caps, knobs, bolts, screws, etc., that are loose, show signs of wear or are missing."

The facility policy, "Side Rail/Bed Rail" was reviewed. This policy documented, "Policy: The Center, will attempt alternative interventions, and document in the medical record, prior to the use of side rail/bed rail. Side rail/bed rail may include but not limited to: Side rails, bed rails, safety rails, grab bars and assist bars. Procedure: 1. Prior to installation of a side rail/bed rail complete the side rail/bed rail evaluation to evaluate the

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resident for risk of entrapment. 2. Review the risk and benefits with the resident and/or resident representative. 3. Obtain consent from the resident and/or resident representative. 4. Obtain physician order for side rail/bed rail. 5. Update the care plan and kardex. 6. Re-evaluate the use of side rail/bed rail, quarterly, with a change in condition or as needed. 7. Follow the manufacturers' recommendations and specifications for installing and maintaining side rails/bed rails."

The policy did not address when and how to conduct any routine or periodic maintenance and inspections of side rails and beds and tracking documentation of these inspections. The facility did not have a manual of the manufacturer's recommendations and specifications for the side rails as documented in the policy. The facility was not logging and tracking routine or periodic bed and side rail inspections.

On 6/29/22 at approximately 1:00 PM, ASM #1 (Administrative Staff Member) the Executive Director, ASM #2 the Director of Nursing, and ASM #3 the Regional Director of Clinical Services, were made aware of the findings. No further information was provided by the end of the survey.